0113

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Crownsville State Hospital

Stay in hospital or inst. (yrs., or mos., or days): 1 mo. 1 day

Stay in this community (yrs., or mos., or days): -----

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore City Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 822 Sharp Street
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: ------

3. (a) FULL NAME: WILLIAM H. ARMS

3. (b) Social Security Number: Ross. 356-09-7681

4. Sex: MALE

5. Color or race: black

6. (a) Single, married, widowed, or divorced: Unknown

6 (b) Name of husband or wife: Unknown

6(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): 1888

8. AGE: Years: 52 Months: Unknown Days: If less than one day: ____ hrs. ____ min.

9. Birthplace: Unknown
(Town, county, and state)

10. Usual occupation: Unknown

11. Industry or business: -----

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Hospital ~~Unknown~~

Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/27-40 (month) (day) (year)

Cemetery or crematory: Hospital

Location: Crownsville Md

18. Funeral director: Supt

Address:

19. 1/27. 40 19 (Date rec'd by registrar) E. F. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 21st 19 40, at 5 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 20th 19 39, to Jan. 21st 19 40 and that I last saw him alive on Jan. 21st 19 40.

Immediate cause of death: General paralysis of the insane

Due to:

Due to: Lues

Other conditions: -----

(Include pregnancy within 3 months of death)

Major findings: -----

Of operations:

Of autopsy: -----

DURATION

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: ---- Date of:

Where did injury occur? ------ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ----

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Crownsville, Maryland Date signed: 1/21/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
FEB 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

0114

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Edgewater P.O

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Contee Farm

Stay in hospital or inst. (yrs., or mos., or days): —

Stay in this community (yrs., or mos., or days): 3½ mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Edgewater P.O. Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Contee Farm

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Robert Hess Asher, Jr.

3. (b) Social Security Number

4. Sex: male

5. Color or race: white

6. (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife: —

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Oct. 9. 1939

8. AGE: Years | Months: 3 | Days: 21 | If less than one day ____ hrs. ____ min.

9. Birthplace: Contee Farm, Edgewater P.O. Md (Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER

12. Name: Robert H. Asher, Sr.

13. Birthplace: Contee Farm, Edgewater P.O. Md.

MOTHER

14. Maiden name: Frances Hess

15. Birthplace: Contee Farm, Edgewater P.O. Md

16. Informant: Robert H. Asher, Sr.

Address: Edgewater P.O. Md.

17. ____ (Burial, cremation, or removal. Which?) Date thereof: Jan. 31, 1940 (month) (day) (year)

Cemetery or crematory: Hope Chapel

Location: Edgewater Md

18. Funeral director: T. G. Hardesty & Son

Address: Gales Ville

19. 1-30 1940 (Date rec'd by registrar) J. J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jany. 30 1940, at 5 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__, to ____ 19__, and that I last saw ____ alive on ____ 19__.

Post mortem examination

Immediate cause of death: Pneumonia (Broncho)

Due to: Icterus neo-natorum

Due to: ____

Other conditions: ____

(Include pregnancy within 3 months of death)

Major findings: Of operations: None

Of autopsy: None

DURATION: History indefinite; 3 mos and 3 weeks

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work? ____

23. SIGNATURE: John M. Claffey Deputy medical examiner M. D. ~~or other~~

Address: Annapolis Md Date signed 1/30/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

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FEB 5 1940
BUREAU V. S.

Tom Ireland

Edward Allen
Lot

STATE OF MARYLAND—CERTIFICATE OF DEATH

0115

1. PLACE OF DEATH (117-a)

County Anne Arundel Registration Dist. No. 23

Village or City Brooklyn Hgts. No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Julius Bader. If U. S. Veteran, specify WAR

(a) Residence: No. 213 Audrey Ave St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	White	✓

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Elizabeth Bader

6. DATE OF BIRTH (month, day, and year) Dec 1, 1853

7. AGE Years	Months	Days	If LESS then 1 day, hrs. or min.
86	1	29	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Window Cleaner

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. Retired

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) France

FATHER

13. NAME Unknown

14. BIRTHPLACE (city or town) (State or country) Unknown

MOTHER

15. MAIDEN NAME Unknown

16. BIRTHPLACE (city or town) (State or country) Unknown

17. INFORMANT (Address) Florence E. Woods. 213 Audrey Ave. Brooklyn Hgts.

18. BURIAL, CREMATION, OR REMOVAL

Place Prospect Hill Towson. Date Feb 2, 1940

19. UNDERTAKER (Address) Leonard J. Carrington 21 W. 25th St

20. FILED Jan 30, 1940 Mrs DeAlba Dep. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Jan (Month) 30 (Day), 1940 (Year)

22. I HEREBY CERTIFY. That I attended deceased from Jan 2, 1940, to Jan 30, 1940

I last saw him alive on , 19 ; death is said to have occurred on the date stated above, at 6 05 p.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Cardio vascular disease (Heart failure)	

Other Contributory Causes of Importance:

Diphtheria

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury , 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Samuel Rubin M. D.

(Address) 213 Galapago ave

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

RECEIVED FEB 8 1928 N.Y.S.

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92d)

CERTIFICATE OF DEATH

0116

Reg. Diat. No. 2 /

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: A.A.

City or town: Camp Parole
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Rural near Annapolis

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 56 Years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: A.A.

City or town: Parole, Rural Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Near Annapolis,
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Thomas S. Barrow

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife: Katie I. Barrow

6(c) If alive, give age: 71 years

7. Birth date of deceased (mo., day, yr.): Jan 20 1865

8. AGE: Years	Months	Days	If less than one day
74	11	13	____hrs. ____min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER
12. Name: Jacob F. Barrow
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary V. Ensey
15. Birthplace: Maryland

16. Informant: Katie I. Barrow
Address: Camp Parole

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 5 1940 (month) (day) (year)

Cemetery or crematory: Edwards Chapel

Location: Camp Parole

18. Funeral director: B.L. Hopping

Address: Annapolis, Md.

19. Jan 5 1940 (Date rec'd by registrar) J.J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 3 1940, at 4 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1 1939, to Jan 3 1940 and that I last saw h[illegible] alive on Jan 3 1940.

Immediate cause of death	DURATION
Acute dilatation of Heart	
Due to Myocarditis Chronic	Oct ?
Due to Arteriosclerosis	unknown
Other conditions Chr. Bronchitis	unknown

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: George C Basil M. D. or other

Address: Annapolis Md. Date signed 1-4-40

RECEIVED
FEB 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

13-E

0117

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH:

County A. A. Co

City or town Glen Burnie Severn P.O. Old Quarterfield Rd Glen Burnie

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 35 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County A A Co

City or town Glen Burnie Old Quarterfield Rd Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Agnes Benton

3. (b) Social Security Number none

4. Sex Female

5. Color or race W

6. (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife George H Benton

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 19 1874

8. AGE: Years 65 Months 11 Days 2 If less than one day hrs. min.

9. Birthplace Pa (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Edward Bortner

13. Birthplace Pa

MOTHER 14. Maiden name Julia Emig

15. Birthplace Pa

16. Informant Mr George H Benton

Address Old Quarterfield Rd

17. Buriel (Burial, cremation, or removal. Which?) Date thereof Jan 24 1940 (month) (day) (year)

Cemetery or crematory Cedar Hill Em

Location Brooklyn Md

18. Funeral director William M Mareck

Address 715 Light St

19. Jan 23 1940 (Date rec'd by registrar) Mr DeAlba Dep Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 21 1940, at 4 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/13/40 19 , to 1/21/40 19 ,

and that I last saw her alive on 1/20/40 19

Immediate cause of death Hypostatic Pneumonia — DURATION 5 days

Due to (Chronic Endocarditis / Arteriosclerosis — unknown

Due to

Other conditions Pulmonary T.B. — unknown

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John J Alexander M. D. or other

Address Glen Burnie Date signed 1/21/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
FEB 5 1946
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0118

Reg. Dist. No. 20

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Anne Arundel
City or town Bristol
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 69 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Bristol Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR None

3. (a) FULL NAME David Bias

3. (b) Social Security Number None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
M.	C	Married

6 (b) Name of husband or wife Mary J. Bias
6(c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Aug 17 1870

8. AGE: Years	Months	Days	If less than one day
69	5	8	hrs. min.

9. Birthplace Drury (Town, county, and state)
10. Usual occupation Fisherman
11. Industry or business Fishing
FATHER 12. Name John Bias
13. Birthplace Unknown
MOTHER 14. Maiden name Caroline Bias
15. Birthplace Unknown
16. Informant Frank Bias
Address Bristol P. O. Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 28 1940 (month) (day) (year)
Cemetery or crematory Walkers Chapel
Location Drury Md.
18. Funeral director T. A. Hardesty & Son
Address Galesville, Md.
19. 1/28/40 (Date rec'd by registrar) 19 W. R. Clayton Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 25 1940, at 6 20 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 14 1940, to Jan 25 1940, and that I last saw h alive on Jan 22 1940.

Immediate cause of death	DURATION
Cerebro Spinal Syphilis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE T. B. Hunt M. D. or other
Address Lothian Md. Date signed

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FEB 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

0119

CERTIFICATE OF DEATH

Reg. Dist. No. 2-4

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Eastport, Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 202 Chesapeake Ave.
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 20 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Eastport, Md. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 202 Chesapeake Ave.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Lillie May Blair

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife: John D. Blair
6(c) If alive, give age: 64 years

7. Birth date of deceased (mo., day, yr.): Dec. 13, 1876

8. AGE: Years	Months	Days	If less than one day
63	24 days		hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: House-wife
11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: John D. Blair
Address: 202 Chesapeake Ave. Eastport, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 9, 1940 (month) (day) (year)
Cemetery or crematory: Cedar Bluff
Location: Annapolis, Md.

18. Funeral director: John M. Taylor
Address: Annapolis, Md.

19. 1-8 1940 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 6 1940, at 12:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July - 1 1939, to Jan 6 1940, and that I last saw her alive on Jan 6 1940.

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to Hypertensive C.V.R. disease	
Arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: C. Pinkard M.D. M. D. or other
Address: Eastport, Md. Date signed 1-6-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
FEB 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0120

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Crownsville State Hospital

Stay in hospital or inst. (yrs., or mos., or days): 3yr. 8mo. 13days

Stay in this community (yrs., or mos., or days): 3yr. 8mo. 13days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore City

City or town: Baltimore Ward No.:

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 130 Bond Street

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: ---

3. (a) FULL NAME: William Blake #2

3. (b) Social Security Number: ---

4. Sex: Male

5. Color or race: Black

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Unknown

6(c) If alive, give age: --- years

7. Birth date of deceased (mo., day, yr.): 1880

8. AGE: Years: 60 Months: Unknown Days: If less than one day: --- hrs. --- min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: ---

FATHER

12. Name: William Hopkins

13. Birthplace: Maryland

MOTHER

14. Maiden name: Annie Virginia Williams

15. Birthplace: Maryland

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. burial (Burial, cremation, or removal. Which?) Date thereof 1-20-40 (month) (day) (year)

Cemetery or crematory: Hospital

Location: Crownsville Md

18. Funeral director: Supt.

Address

19. 1/20/40 (Date rec'd by registrar) 19--- E J Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 15th 1940, at 3:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 2nd, 1936, to January 15 1940, and that I last saw h[im] alive on January 15 1940.

	DURATION
Immediate cause of death: Broncho Pneumonia	2days
Due to: Manic Exhaustion	
Due to: ---	
Other conditions: ---	

(Include pregnancy within 3 months of death)

Major findings:

Of operations: ---

Of autopsy: ---

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: --- Date of: ---

Where did injury occur? --- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ---

Means of injury: --- Injured at work? ---

23. SIGNATURE: Hal L. Hinkle M. D. or other

Address: Crownsville, Md. Date signed: 1/15/40

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FEB 5 1940
BUREAU V. S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

0121

92-d

1. PLACE OF DEATH

County ANNE ARUNDEL Registration Dist. No. 21

Village or City SEVERNA PARK No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U.S. if of foreign birth? ____ yrs. ____ mos. ____ ds.

2. FULL NAME Richard C. Brockmeyer If U. S. Veteran, specify WAR

(a) Residence: No. SEVERNA PARK St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
M	W	MARRIED

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Barbara R. Ullrich

6. DATE OF BIRTH (month, day, and year) Sept. 10 - 1888

7. AGE Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
51	5	26	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Storekeeper

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. Grocery

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Putty Hill (State or country) Md.

FATHER

13. NAME Chas. Brockmeyer

14. BIRTHPLACE (city or town) Md. (State or country)

MOTHER

15. MAIDEN NAME Catherine Krastel

16. BIRTHPLACE (city or town) Md. (State or country)

17. INFORMANT Mrs. R. C. Brockmeyer (Address) Severna Park.

18. BURIAL, CREMATION, OR REMOVAL Place Holy Redeemer Date 1/9, 1940

19. UNDERTAKER J. F. McCully (Address) 130 E. Fort Ave.

20. FILED 1-6, 1940 L. A. Brew Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Jan (Month) 6 (Day), 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from September, 1939, to Jan 6, 1940

I last saw him alive on January 4, 1940; death is said to have occurred on the date stated above, at 6:45 a.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Ac. Pulmonary Edema	1/6/40

Other Contributory Causes of Importance:

Aortic & mitral insufficiency

Chr. myocarditis

Name of operation none Date of

What test confirmed diagnosis? Clinical Was there an autopsy? no

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) Maurice F. Klowans M. D.

(Address) 31 South Gate Av.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

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Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-L)

0122

CERTIFICATE OF DEATH

Reg. Dist. No. 2-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel Co.
City or town: Camp Parke - Md
(If outside city of town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: No number
Stay in hospital or inst. (yrs., or mos., or days): No
Stay in this community (yrs., or mos., or days): 40 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A.A. Co.
City or town: Camp Parke - Md. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: No number.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Elizabeth Brown

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col	married

B (b) Name of husband or wife: Joseph Brown
6(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): May 15, 1872

8. AGE: Years	Months	Days	If less than one day
67	8	5	hrs. min.

9. Birthplace: Washington D.C. (Town, county, and state)
10. Usual occupation: Housework (Unemployed)
11. Industry or business: Home
FATHER 12. Name: William F. Walker
FATHER 13. Birthplace: Va
MOTHER 14. Maiden name: Mary Olivia Shorter
MOTHER 15. Birthplace: Prince George Co Md
16. Informant: Elizabeth Brown
Address: Camp Parke
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 23/40 (month) (day) (year)
Cemetery or crematory: Bladen Hill
Location: Annapolis
18. Funeral director: J. B. Johnson
Address: Annapolis
19. 1-23 (Date rec'd by registrar) 1940 J. J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 20 1940, at 7 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 27 1939, to Jan. 20, 1940, and that I last saw h-er alive on Jan. 20 1940.

	DURATION
Immediate cause of death: Myocarditis (Acute)	1 day
Due to: (Cause Unknown)	
Due to:	
Other conditions: Arteriosclerotic - Cardio-Vascular disease	2 years

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Albert L. Anderson M.D.
M. D. or other
Address: Annapolis, Md. Date signed: 1/27/40

RECEIVED
FEB 5 1948
BUREAU Y. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (61)

0123

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days): 15 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Jones Station Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: Near Jones Station
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Emma Brown

3. (b) Social Security Number: None

4. Sex: Female
5. Color or race: Col.
6. (a) Single, married, widowed, or divorced: Single
8 (b) Name of husband ~~or wife~~: None
6(c) If alive, give age: X years
7. Birth date of deceased (mo., day, yr.): 1890

8. AGE: Years: 50 Months: 58 Days: If less than one day: hrs. min.

9. Birthplace: unknown (Town, county, and state)
10. Usual occupation: laundress
11. Industry or business: X

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: Mrs Madier Zimmerman
Address: Serverna Park Md.

17. (Burial, cremation, ~~or removal. Which?~~) Date thereof: Jan 18 1940 (month) (day) (year)
Cemetery or crematory: Wyman Good Hope Cemetery
Location: Jones Station

18. Funeral director: Chas. H. Alexander
Address: 43.45 Northwest St. Annapolis Md.

19. 1 18 1940 (Date rec'd by registrar) J. J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 16 1940, at 11 30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 17 1940, to Jan 16 1940, and that I last saw her alive on Jan 15 1940.

Immediate cause of death: Diabetes mellitus — DURATION: unknown
Due to
Due to
Other conditions: Diabetic Gangrene — 6 wks
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: John J. Alexander M. D. or other
Address: Glen Burnie Md. Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
FEB 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (11)

0124

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 12 Calvert Court
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 15yr 1Mo. 2da.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis Ward No. 4
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 12 Calvert Court
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Emma Brown

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col.	Married

6 (b) Name of husband or wife: Deceased

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 12 1874

8. AGE: Years	Months	Days	If less than one day
66	66	11	hrs. min.

9. Birthplace: Gothian Anne Arundel Maryland
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Wesley Mothers
13. Birthplace:

MOTHER
14. Maiden name: Flora Mothers
15. Birthplace: Gothian Md.

16. Informant: Marshall Brown
Address: 38 Fleet St. Annapolis Md.

17. (Burial, cremation, or removal. Which?) Date thereof 2-4-40 (month) (day) (year)
Cemetery or crematory: Mt. Zion Cemetery
Location: Gothian Md.

18. Funeral director: Chas. H. Alexander
Address: 43, 45 Northwest St. Annapolis, Md.

19. 2-2-40 (Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 31, 1940, at 11:05 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 5 1940, to Jan 31, 1940, and that I last saw h[illegible] alive on Jan. 31, 1940

Immediate cause of death	DURATION
Diabetes Mellitus	3 yrs
Due to: Diabetes	
Due to:	
Other conditions: Gangrene of left leg with left foot	16 days

(Include pregnancy within 3 months of death)

Major findings:
0t operations:
0t autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Albert L. Anderson M.D.
M. D. or other
Address: Annapolis, Md. Date signed 2/2/40

RECEIVED
MAR 5 1940
BUREAU V. S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

0125

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

1. PLACE OF DEATH

County Anne Arundel Registration Dist. No. 21

Village or City Crownsville State Hospital No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where daath occurrad 2 yrs. 5 mos. 1 ds. How long in U.S. If of foreign birth? -- yrs. mos. ds.

2. FULL NAME Brown (Hennegan) James Leroy If U. S. Veteran, specify WAR --

(a) Residence: No. Baltimore City St., Ward. (street address not given)

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write tha word)
Male	Black	Single

5a. If married, widowad, or divorced HUSBAND of (or) WIFE of --

6. DATE OF BIRTH (month, day, and year) March 1924

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	15	10		

OCCUPATION

8. Trade, profession, or particular kind of work dona, as SPINNER, SAWYER, BOOKKEEPER, etc. none

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. none

10. Data daceased last worked at this occupation (month end year) --

11. Total tima (years) spent in this occupation --

12. BIRTHPLACE (city or town) Baltimore (State or country) Maryland

FATHER

13. NAME John (Hennegan) Brown

14. BIRTHPLACE (city or town) N.C. (State or country)

MOTHER

15. MAIDEN NAME Mary Morgan

16. BIRTHPLACE (city or town) unk. (State or country) Maryland

17. INFORMANT Hospital Records (Address) Crownsville, Maryland

18. BURIAL, CREMATION, OR REMOVAL Placa Crownsville Cemetery Date 1/17/40

19. UNDERTAKER Mr. Tydings (Address) Crownsville, Maryland

20. FILED 1/17, 19 40 E. F. Joyce Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH January (Month) 13 (Day) 1940 (Year)

22. I HEREBY CERTIFY, That I attandad decaesed from Aug. 12, 19 37 to Jan. 13, 19 40

I last saw him alive on Jan. 13, 19 40; daath is said to have occurred on the data stated abova, at 9 P.M.

Tha **PRINCIPAL CAUSE OF DEATH** and ralated causes of importanca were as follows:

	Date of onset
Acute Desseminated Tuberculosis	unk.

Other **Contributory Causes** of Importanca:

Tuberculosis of Meninges and central nervous system	

Name of oparation none Date of --

What test confirmed diagnosis? -- Was there an autopsy? yes

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? -- Date of injury -- , 19

Where did injury occur? --

(Specify city or town, county and State)

Specify whether injury occurrad in INDUSTRY, in HOME, or in PUBLIC PLACE. --

Manner of injury --

Nature of injury --

24. Wes diseasa or injury in eny way related to occupation of deceasad? --

If so, specify --

(Signed) Gustave A. Lambert M.D. M. D.

(Address) Crownsville, Maryland

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0126

Reg. Dist. No. 27

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County A. A. Co.
City or town Annapolis md (If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Emergency Hospital
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Md County A. A. Co.
City or town Annapolis Ward No. (If outside city or town limits, write RURAL NEAR and give town)
Street No. 18 Block Street (If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Loyd Brown

3. (b) Social Security Number Pens. 206-09-1642

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
male	colored	Widowed

6 (b) Name of husband or wife Mary Brown
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years	Months	Days	If less than one day
65			hrs. min.

9. Birthplace A. A. Co. (Town, county, and state)
10. Usual occupation Oysterman
11. Industry or business

FATHER
12. Name Robert Brown
13. Birthplace A. A. Co.

MOTHER
14. Maiden name Sophia Wells
15. Birthplace Prince George Co.

16. Informant William J. Brown
Address 1324 N. Gilmore St Baltimore Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 5 1940 (month) (day) (year)
Cemetery or crematory Mt. Calvary
Location Arnol Md

18. Funeral director J. B. Johnson
Address Annapolis Md

19. Jan 5 1940 (Date rec'd by registrar) J. J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 1 1940, at 2:35 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw him alive on 19

Post mortem Exam

	DURATION
Immediate cause of death Lobar Pneumonia	not known
Due to (both lower lobes affected	
Due to lived about 12 hours after admission to hospital	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations None
Of autopsy None

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John M. Caffy Deputy Medical Examiner
M. D. or other
Address Annapolis Md Date signed 1/4/40

RECEIVED
FEB 8 1940
BUREAU V. S.

0127

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 25

1. PLACE OF DEATH:

County Anne Arundel

City or town Brooklyn
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or insf. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 3 yr 5 m

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County A A Co

City or town Church st + Wasina Ave Ward No. Brooklyn md
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME William J Budahazy

3. (b) Social Security Number none

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug 28 1936

8. AGE: Years 3 Months 4 Days 30 If less than one day ___ hrs. ___ min.

9. Birthplace Brooklyn Md
(Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER
12. Name John A Budahazy
13. Birthplace Balto

MOTHER
14. Maiden name Emma K Gischel
15. Birthplace Curtis Bay

16. Informant John A Budahazy
Address Church + Wasina Ave

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof Jan 30 1940 (month) (day) (year)

Cemetery or crematory Holy Cross

Location Brooklyn Md

18. Funeral director William M Mareck

Address 715 Light St

19. Jan 29 1940 Ida M. Whitson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jany. 27 1940, at 10 45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ___ to ___ 19__, and that I last saw h ___ alive on ___ 19__.

Post mortem examination

Immediate cause of death

Due to Lobar Pneumonia — Duration: two or three days.

Due to Convulsions

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations none

Of autopsy none

DURATION: 2 days; sudden death

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work

23. SIGNATURE John M. Caffy Deputy medical examiner M. D. or other

Address Annapolis Md Date signed 1/27/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 30 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (51-P)

CERTIFICATE OF DEATH

Reg. Dist. No. 21 0128

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: A. A.
City or town: Parole
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 16 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A. A.
City or town: Parole Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: John Butler

3. (b) Social Security Number: 214-18-7345

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife: Georgianna Butler
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept 1889

8. AGE: Years	Months	Days	If less than one day
50	4		hrs. min.

9. Birthplace: A. A. Co. 8th Dist.
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business
FATHER 12. Name: John Henry Butler
13. Birthplace: A. A.
MOTHER 14. Maiden name: Mary Owens
15. Birthplace: A. A.
16. Informant: James Edward Butler
Address: Tracys Landing
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 23 1940 (month) (day) (year)
Cemetery or crematory: Union Chapel
Location: Bristol Md
18. Funeral director: J. B. Johnson
Address: Annapolis
19. 1 23 1940 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 20 1940, at 12:50 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 19 1939, to Jan 20 1940, and that I last saw him alive on Jan 20 1940.

Immediate cause of death: Carcinoma of Prostate gland — DURATION: ?
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Lawrence W. Greene, M.D.
(M. D. or other)
Address: Annapolis, Md. Date signed: 1/22/40

RECEIVED
FEB 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (106-a)

CERTIFICATE OF DEATH

0129
21
Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County A. A.
City or town Sharonmore
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Sharonmore
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County A. A.
City or town Sharonmore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Lillie Hayes Carr

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem	Colored	widow

6 (b) Name of husband or wife Edward Carr
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 5 1879

8. AGE: Years	Months	Days	If less than one day
60	0	6	hrs. min.

9. Birthplace A. A. Co (Town, county, and state)
10. Usual occupation Housework
11. Industry or business

FATHER
12. Name Isaac Johnson
13. Birthplace A. A. Co

MOTHER
14. Maiden name Annie Johnson
15. Birthplace A. A. Co

16. Informant George M. Hayes
Address Sharonmore

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 14 1940 (month) (day) (year)
Cemetery or crematory Brookneck
Location A. A.

18. Funeral director J. B. Johnson
Address Annapolis

19. 1/14 1940 (Date rec'd by registrar) J. Munroe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 10 1940, at 7:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 4 1940, to Jan. 10 1940, and that I last saw her alive on Jan. 10 1940.

	DURATION
Immediate cause of death: Myocardial Insufficiency	2 days
Due to: Acute Bronchitis	10 days
Due to: Arterial Hypertension	Unknown
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations: None
Of autopsy: None

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. Willis Martin M.D.
M. D. or other
Address Annapolis Md Date signed 1/11/40

RECEIVED
FEB 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-D)

CERTIFICATE OF DEATH

0130

Reg. Dist. No. 21

1. PLACE OF DEATH: Anne Arundel

County

City or town Crownsville

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Crownsville State Hospital

Stay in hospital or inst. (yrs., or mos., or days) 17 yrs. 10 mos. 1 day

Stay in this community (yrs., or mos., or days) -----

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore County

City or town Monkton, Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. Unknown

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR -------

3. (a) FULL NAME LUKE CAUTION

3. (b) Social Security Number -------

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
male	black	married

6 (b) Name of ~~husband~~ or wife Unknown

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) 1865

8. AGE: Years 75 | Months Unknown | Days | If less than one day ____ hrs. ____ min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business -----

FATHER 12. Name Unknown

13. Birthplace Uknown

MOTHER 14. Maiden name Unknown

15. Birthplace Unknown

16. Informant Hospital Records

Address Crownsville, Maryland

17. burial (Burial, cremation, or removal. Which?) Date thereof 1/27-40 (month) (day) (year)

Cemetery or crematory Hospital

Location Crownsville

18. Funeral director Supt.

Address

19. 1/27 1940 (Date rec'd by registrar) E. F. Joyce DD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 22nd 1940, at 9:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 21st 1922, to Jan. 22nd 1940, and that I last saw him alive on Jan. 22nd 1940.

Immediate cause of death Chronic myocarditis

Due to

Due to

Other conditions -------

(Include pregnancy within 3 months of death)

Major findings: -------

Of operations

Of autopsy -----

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ---- Date of

Where did injury occur? ----- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -------

Means of injury Injured at work? -----

23. SIGNATURE [signature] M. D. or other

Address Crownsville, Maryland Date signed 1/22/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(M) (T)

RECEIVED
FEB 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

WITHIN CORPORATE LIMITS (94a)

CERTIFICATE OF DEATH

Reg. Dist. No. 21 0131

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis, Maryland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: U.S.Naval Hospital Annapolis, Maryland

Stay in hospital or inst. (yrs., or mos., or days): 7 days

Stay in this community (yrs., or mos., or days): 80 yrs. 5 mos. 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis, Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 15 Franklin Street
(If rural give LOCATION)

(2a) IF VETERAN, NAME WAR: Spanish American World War

3. (a) FULL NAME: Robert Vinton CLAYTON

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Lula Basil Clayton

Alive (incompetent) 6(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): August 20, 1859

8. AGE:

Years	Months	Days	If less than one day
80	5	5	____ hrs. ____ min.

9. Birthplace: Annapolis, Anne Arundel, Maryland
(Town, county, and state)

10. Usual occupation: Chief Printer, U.S.Navy, (RETIRED)

11. Industry or business:

FATHER
12. Name: No information available
13. Birthplace: "

MOTHER
14. Maiden name: No information available
15. Birthplace: R. M. Lhamon "

16. Informant: R. M. Lhamon, Captain, (MC), USN.
Address: U. S. Naval Hospital Annapolis, Md.

17. Burail (Burial, cremation, or removal. Which?) Date thereof: Jany. 26, 1940 (month) (day) (year)

Cemetery or crematory: St. Anne's Cemetery

Location: Annapolis, Md.

18. Funeral director: John M. Taylor

Address: 147 Duke of Gloucester St. Annapolis, Maryland

19. 1-25-1940 (Date rec'd by registrar) J. M. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 24 1940, at 8:20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 18 1940, to January 24 1940, and that I last saw him alive on January 24, 1940

Immediate cause of death: Thrombosis coronary artery — DURATION: 7 days

Due to: —

Due to: —

Other conditions: —

(Include pregnancy within 3 months of death)

Major findings:

Of operations: —

Of autopsy: Rupture infarct left ventricle

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ---- Date of: ----

Where did injury occur? ---- ---- ----
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ----

Means of injury: ---- Injured at work? ----

23. SIGNATURE: R. L. Ware, M.D.

Address: Lieutenant, Medical Corps, U.S.N. U.S.Naval Hospital Annapolis, Maryland. Date signed: 1-25-40
M.D. or other

RECEIVED
FEB 5 1940
BUREAU V. S.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(93-2)

0132

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town Herald Harbor
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: —
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 1 year 3 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Herald Harbor, Crownsville P.O. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. Serpentine Trail.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Forest Wesley Cutler

3. (b) Social Security Number 214-05-0633.

4. Sex: male
5. Color or race: White
6. (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Meta Silvey Cutler
6(c) If alive, give age 33 years
7. Birth date of deceased (mo., day, yr.) Feby 27, 1901.

8. AGE: Years 38 | Months 11 | Days 9 | If less than one day ___ hrs. ___ min.

9. Birthplace Hudson Falls, N.Y.
(Town, county, and state)
10. Usual occupation chauffeur & service man
11. Industry or business oil-business
FATHER
12. Name Hiram W. Cutler
13. Birthplace Argyle, N.Y.
MOTHER
14. Maiden name Mary L. Evans
15. Birthplace Luzerne, N.Y.
16. Informant Le Roy Stitt
Address Herald Harbor
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 20-40 (month) (day) (year)
Cemetery or cremator Severn Cross Roads
Location Millersville Maryland
18. Funeral director B B Williams
Address Waterway - Md.
19. 1/20 — 1940 (Date rec'd by registrar) E. F. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jany. 18 1940, at 6 30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Post-mortem examination
and that I last saw h ___ alive on ___ 19___
Immediate cause of death: Acute Myocardial
Due to Failure.
Due to Death was sudden No history of previous illness. C.W.G.R.
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations none done
Of autopsy none done

DURATION: Sudden

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ___ Date of ___
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ___ Injured at work?

23. SIGNATURE John M. Caffy Deputy medical examiner M. D. or other
Address Annapolis, Md. Date signed 1/18/40

RECEIVED
FEB 5 1946
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

0133

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Crownsville State Hospital

Stay in hospital or inst. (yrs., or mos., or days): 15yr. 6mo.

Stay in this community (yrs., or mos., or days): 15yr. 6mo.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: At Large

City or town: Baltimore City Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Unknown
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: --------

3. (a) FULL NAME: Samuel Dare

3. (b) Social Security Number: -------

4. Sex: Male

5. Color or race: Black

8.(a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: Unknown

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): 1901

8. AGE: Years: 39 Months: Unknown Days: If less than one day ____ hrs. ____ min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: --------

FATHER
12. Name: John Dare
13. Birthplace: Maryland

MOTHER
14. Maiden name: Annie Read
15. Birthplace: Maryland

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. burial (Burial, cremation, or removal. Which?) Date thereof 1/17. 40 (month) (day) (year)

Cemetery or crematory: Hospital

Location: Crownsville Md

18. Funeral director: Supt.

Address: Crownsville Md

19. 1/17. 1940 (Date rec'd by registrar) E. F. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 12, 1940, at 4:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 13 1914, to January 12 1940, and that I last saw him alive on January 12 1940.

Immediate cause of death: Pulmonary Hemorrhage

Due to: Pulmonary Tuberculosis

Due to: Paranoid Condition

Other conditions: --------
(Include pregnancy within 3 months of death)

Major findings:

Of operations: --------

Of autopsy: -------

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: --- Date of: ---

Where did injury occur? --- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Crownsville, Md. Date signed: 1/13/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
FEB 5 1940
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (86)

0134

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County H. A.

City or town Parole

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County H. A.

City or town Parole Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Harrie Rebecca Donnell

3. (b) Social Security Number

4. Sex: Fem

5. Color or race: Colored

6. (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

8 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 19 1939

8. AGE: Years | Months | Days 21 | If less than one day hrs. min.

8. Birthplace Parole (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name James Donnell

13. Birthplace West River

MOTHER

14. Maiden name Florence L. Johns

15. Birthplace Parole Md

18. Informant James Donnell

Address Parole Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 15 1940 (month) (day) (year)

Cemetery or crematory Brewer Hill

Location Annapolis Md

18. Funeral director J. B. Johnson

Address Annapolis

19. 1-16 1940 (Date rec'd by registrar) J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 14 1940, at 7:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on Post mortem exam. 19

Immediate cause of death: Convulsions

DURATION: sudden

Due to No history of preceding illness. Congenital debility was probable cause

Due to of the convulsions. C.W.R.

Other conditions

(Include pregnancy within 8 months of death)

Major findings:

Of operations None

Of autopsy None

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John M. Caffy Deputy medical M. D. or other

Address Annapolis Md. Date signed 1/15/40

RECEIVED
FEB 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(93-d)

0135

CERTIFICATE OF DEATH

Reg. Dist. No. 25

1. PLACE OF DEATH:

County Anne Arundel

City or town Point Pleasant

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or ~~mos., or days~~) 1 yr

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County A A Co Md

City or town Point Pleasant Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. Point Pleasant Rd

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Elizabeth C Dougherty

3. (b) Social Security Number none

4. Sex Female

5. Color or race W

6. (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife William F.

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 26 1869

8. AGE: Years 70 Months 9 Days 5 If less than one day hrs. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual occupation House work at home

11. Industry or business

FATHER 12. Name Louis Plitt

13. Birthplace Germany

MOTHER 14. Maiden name unknown

15. Birthplace Germany

16. Informant Mrs Dorothy Cook

Address Point Pleasant, A A Co

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 3 1940 (month) (day) (year)

Cemetery or crematory Baltimore Cem

Location E. North Ave Ext

18. Funeral director William M Mareck

Address 715 Light St

19. Feb 2 1940 Ida M. Whitson (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 31 1940, at 6 20 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1939, to Jan 31 1940 and that I last saw h r alive on Jan 31 1940.

Immediate cause of death Bronchopneumonia (Terminal) — DURATION one week

Due to Hypertrophic degenerative arteritis — 1 yr

Due to

Other conditions Myocarditis chronic — 1 yr

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Isaac Miller M. D. or other

Address 1228 N Charles St Date signed 2/2/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(T)

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FEB 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0136

Reg. Dist. No. 24

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Crownsville State Hospital

Stay in hospital or inst. (yrs., or mos., or days): 1yr. 1mo. 2days

Stay in this community (yrs., or mos., or days): 1yr. 1mo. 2days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Unknown Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Unknown

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: ------

3. (a) FULL NAME: Joseph Dunkins

3. (b) Social Security Number: No record - DAD

4. Sex: Male

5. Color or race: Black

6. (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Unknown

6(c) If alive, give age: ------ years

7. Birth date of deceased (mo., day, yr.): 1879 (?)

8. AGE: Years: 61 (?) Months: Unknown Days: ------ If less than one day: ------ hrs. ------ min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: Janitor

11. Industry or business: ------

FATHER

12. Name: Edward Dunkins

13. Birthplace: Virginia

MOTHER

14. Maiden name: Maudie (Unknown)

15. Birthplace: Virginia

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. (Burial, cremation, or removal. Which?) burial Date thereof 1/20 - 40 (month) (day) (year)

Cemetery or crematory: Hospital

Location: Crownsville

18. Funeral director: Supt.

Address

19. (Date rec'd by registrar) 1/20 1940 Registrar E. T. Joyce

MEDICAL CERTIFICATION

20. DATE OF DEATH January 12, 1940, at 9:50 PM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from December 10 1938, to January 12 1940 and that I last saw h... in ...alive on January 12 1940.

Immediate cause of death: General Paresis of Insane — DURATION

Due to: ------

Due to: ------

Other conditions: ------

(Include pregnancy within 3 months of death)

Major findings:

Of operations: ------

Of autopsy: ------

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ------ Date of: ------

Where did injury occur? ------ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Albert H. Smith M. D. or other

Address: Crownsville, Md. Date signed 1/13/40

RECEIVED
FEB 5 1948
BUREAU V. S.

0137

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8)

WITHIN CORPORATE LIMITS OF

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County A.A.

City or town Annapolis, Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Emergency Hospital

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County A.A.

City or town Rural Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. St. Margarets, Md.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Infant, Ehle

3. (b) Social Security Number None

4. Sex M.

5. Color or race W

6. (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan23 L940

8. AGE: Years | Months | Days | If less than one day hrs. min.

9. Birthplace Annapolis, Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name Paul S Ehle
13. Birthplace Mass,

MOTHER
14. Maiden name Ellen C, Parkinson
15. Birthplace Annapolis, Md.

16. Informant Paul S. Ehle
Address St.Margarets

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 25.1940 (month) (day) (year)

Cemetery or crematory St. Anne's

Location Annapolis, Md.

18. Funeral director B.L.Hopping
Address Annapolis, Md.

19. 1 25 (Date rec'd by registrar) 19 40 J. [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 23 1940, at 3A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Delivered Still, to born 19

and that I last saw h alive on 19

Immediate cause of death Still Born - 8th Month.

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE George C Basil
M. D. or other

Address Annapolis Md Date signed 1 25

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
FEB 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (46E)

CERTIFICATE OF DEATH

0138

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Crownsville State Hospital
Stay in hospital or inst. (yrs., or mos., or days): 1 month
Stay in this community (yrs., or mos., or days): ------

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore City
City or town: Baltimore City Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 810 Sterling St.,
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: ---

3. (a) FULL NAME: Charles Elliott

3. (b) Social Security Number: No record — OAD

4. Sex: male
5. Color or race: black
6. (a) Single, married, widowed, or divorced: widowed
6 (b) Name of husband or wife: ---
6(c) If alive, give age: ---- years
7. Birth date of deceased (mo., day, yr.): 1890
8. AGE: Years: 50 Months: Unknown Days: If less than one day: ---- hrs. ---- min.
9. Birthplace: South Carolina (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: ---
FATHER 12. Name: Lawrence Elliott, dead
13. Birthplace: South Carolina
MOTHER 14. Maiden name: Lula Hellion
15. Birthplace: South Carolina
16. Informant: Hospital Records
Address: Crownsville, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/17/40 (month) (day) (year)
Cemetery or crematory: Hospital
Location: Crownsville Md
18. Funeral director: Supt.
Address: Crownsville Md
19. 1/17 1940 (Date rec'd by registrar) E. F. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 8th 1940, at 1:30 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 8th, 1939, to Jan. 8th 1940, and that I last saw him alive on Jan. 8th 1940.
Immediate cause of death: Carcinoma of stomach - pyloric region
Due to: Operated on at Mercy Hospital Baltimore, previous to admission here.
Due to:
Other conditions: Pernicious anemia
Psychosis due to new growth.
(Include pregnancy within 3 months of death)
Major findings:
Of operations: ---
Of autopsy: ---
DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: ---- Date of:
Where did injury occur? ---- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ---
Means of injury: ---- Injured at work?

23. SIGNATURE: Herb. P. Minkerode M. D. or other
Address: Crownsville, Md. Date signed: 1/8/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 (T) (M)

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FEB 5 1968
BUREAU V. S.

0139

STATE OF MARYLAND—CERTIFICATE OF DEATH

83-a

1. PLACE OF DEATH

County Anne Arundel Registration Dist. No. 21

Village or City Pasadena No. near Tickneck Rd St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 57 yrs. 0 mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Ida V. Ellis If U. S. Veteran, specify WAR

(a) Residence: No. near Tickneck Rd St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female

4. COLOR OR RACE Negro

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Morris Ellis

6. DATE OF BIRTH (month, day, and year) May 15, 1882

7. AGE Years 57 Months 8 Days 2 If LESS than 1 day, hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Housework

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. Farm

10. Date deceased last worked at this occupation (month and year) 9 yrs

11. Total time (years) spent in this occupation 38

12. BIRTHPLACE (city or town) (State or country) Anne Arundel Co

FATHER

13. NAME Charles Walker

14. BIRTHPLACE (city or town) (State or country) ~~Charles Walker~~ Maryland

MOTHER

15. MAIDEN NAME not

16. BIRTHPLACE (city or town) (State or country) none known

17. INFORMANT (Address) Marcelline Crowner. Pasadena. Md

18. BURIAL, CREMATION, OR REMOVAL

Place Magothy Date Jan 21, 1940

19. UNDERTAKER (Address) William A Jackson 916 Penna Ave

20. FILED 1-17, 1940 L. A. Brent Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Jany. (Month) 17 (Day) 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from 19 to 19

I last saw h Post mortem Exam. live on 19; death is said to have occurred on the date stated above, at 10 05 A m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Cerebral Hemorrhage	sudden

Other Contributory Causes of Importance:

Arterial Hypertension	not known

Name of operation None Date of —

What test confirmed diagnosis? — Was there an autopsy? no

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of Injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of Injury

Nature of Injury

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) John M. Claffy Deputy medical examiner M.D.

(Address) Annapolis Md

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

T

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I		Example II	
The principal cause of death and related causes of importance were as follows:	Date of onset	The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*	*Attack of epilepsy*	*1 week ago*
Chronic interstitial nephritis	*1921*	*Run over by street car*	*1 week ago*
Cerebral hemorrhage	*July 5, 1927*	*Peritonitis*	*3 days ago*
Other contributory causes of importance:		Other contributory causes of importance:	
Gallstones	*May 1, 1923*	*Gastroenteritis*	*1 year*

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ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

STATE OF MARYLAND—CERTIFICATE OF DEATH

0140

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

1. PLACE OF DEATH

County Anne Arundel Registration Dist. No. 20

Village or City Sothian ND. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurrad 3 yrs. 2 mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME John Alexander Fairall If U. S. Veteran, specify WAR

(a) Residence No. Upper Marlboro, Md St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Nellie Fairall

6. DATE OF BIRTH (month, day, and year) Oct 3-1860

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
79	3	19	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Retired Guard

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year) Oct 1939

11. Total time (years) spent in this occupation 10

12. BIRTHPLACE (city or town) (State or country) Prince Geo. Co., Md "

FATHER

13. NAME John A. Fairall

14. BIRTHPLACE (city or town) (State or country) Prince Geo. Co., Md "

MOTHER

15. MAIDEN NAME Henrietta Lynch

16. BIRTHPLACE (city or town) (State or country) Prince George Co Md

17. INFORMANT (Address) Mrs. Alice Greenwell Sothian, Md

18. BURIAL, CREMATION, OR REMOVAL Cedar Hill Cemty Date 1/25, 1940

19. UNDERTAKER Ritchie Brothers (Address) Upper Marlboro, Md

20. FILED 1/23, 1940 W. R. Clayton Deputy Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH January (Month) 22 (Day), 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from Jan 22, 1940 to Jan 22, 1940

I last saw him alive on Jan 16, 1940; death is said to have occurred on the date stated above, at 3:30 p.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Unknown	

Other Contributory Causes of Importance:

Hypertensive Cardio-Renal Disease	

Name of operation None Date of —

What test confirmed diagnosis? None Was there an autopsy? No

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? No Date of injury —, 19

Where did injury occur? No (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury None

Nature of Injury

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) James E. Janeen M. D.

(Address) Upper Marlboro Md

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

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FEB 6 1940
BUREAU V. S.

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0141

Reg. Dist. No. 23

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH

County A A Co

City or town A A Co Elmhurst Owing Estate

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days) none

Stay in this community (yrs., or mos., or days) none

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Severna P.O. County A A Co

City or town Elmhurst Estate Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. A A Co

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR none

3. (a) FULL NAME William H. Fosler

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Anna N Fosler

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Nov 21, 1849

8. AGE: Years 90 | Months 2 | Days 7 | If less than one day ____ hrs. ____ min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Farmer

FATHER 12. Name Unknown

13. Birthplace Unknown

MOTHER 14. Maiden name Unknown

15. Birthplace Unknown

16. Informant Jacob M Fosler

Address 2908 Hillcrest Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 31, 1940 (month) (day) (year)

Cemetery or crematory Baltimore Cemetery

Location Federal St

18. Funeral director William Cook

Address 1217 St Paul St

19. Jan 29 1940 (Date rec'd by registrar) M DeAlba Dep. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 29, 1940, at 2 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1939, to Jan 29, 1940, and that I last saw him alive on Jan 28, 1940.

Immediate cause of death	DURATION
Senility	1 yr
Due to Hypostatic congestion of lungs	1 week
Due to Congestive heart failure, due to the strained pulmonary circulation	
Other conditions None. Patient gradually became weaker and weaker.	

(Include pregnancy within 3 months of death)

Major findings:

Of operation ____

Of autopsy ____

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE Harvey M. Moore Jr M.D. M. D. or other

Address Glen Burnie, Md Date signed Jan 29, 1940

RECEIVED
JAN 31 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46d)

0142

CERTIFICATE OF DEATH

Reg. Diat. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 4 Acton Place

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 56 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: A. A. Co.

City or town: Annapolis Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 4 Acton Place
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: World War

3. (a) FULL NAME: JOHN MARTIN GREEN

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Sara Sutherland Green

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 18, 1884

8. AGE: Years	Months	Days	If less than one day
56		3	hrs. min.

9. Birthplace: Annapolis, Md.
(Town, county, and state)

10. Usual occupation: Treas. of A. A. County

11. Industry or business

FATHER
12. Name: Richard H. Green
13. Birthplace: Annapolis, Md.

MOTHER
14. Maiden name: Harriet Kent
15. Birthplace: A. A. Co. Md.

16. Informant: Sara Sutherland Green
Address: Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 23, 1940 (month) (day) (year)

Cemetery or crematory: St. Anne's Cemetery

Location: Annapolis, Md.

18. Funeral director: John M. Taylor

Address: Annapolis, Md.

19. 1-23-40 (Date rec'd by registrar) J. J. Murphy (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: ~~Dec~~ Jan 21 1940, at 4 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1939, to Jan 21 1940, and that I last saw him alive on Jan 21 1940.

Immediate cause of death: Carcinoma recto sigmoid — DURATION: 1 year

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations: Intestinal Obstruction. Carcinoma recto sigmoid

Of autopsy: None

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: J. Willis Martin M. D.
M. D. or other

Address: Annapolis Md Date signed: 1/22/40

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-1)

CERTIFICATE OF DEATH

0143

Reg. Dist. No. 23

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Prince Georges
City or town (If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Ham. Ferry Rd & Greenwood Rd
Stay in hospital or inst. (yrs., or mos., or days) —
Stay in this community (yrs., or mos., or days) 12 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Balto. a.a.
City or town Suitland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. Ham. Ferry Rd. & Greenwood (If rural give LOCATION)
2(a) IF VETERAN, NAME WAR None

3. (a) FULL NAME Emil Griffner

3. (b) Social Security Number 22-0-07-9731+

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
M	W.	Married

6 (b) Name of husband or wife Minnie Schmidt
6(c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) Mar 23, 1880

8. AGE: Years	Months	Days	If less than one day
59	10	29	____hrs. ____min.

9. Birthplace Germany (Town, county, and state)
10. Usual occupation Boat Builder
11. Industry or business Coast Guard

FATHER
12. Name Adolph Griffner
13. Birthplace Germany

MOTHER
14. Maiden name Caroline ?
15. Birthplace Germany

16. Informant Mrs. Minnie Griffner
Address Ham. Ferry Rd & Greenwood

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 25 1940 (month) (day) (year)
Cemetery or crematory Emmanuel Cem.
Location Kingdom Land
18. Funeral director L. Kleemann & Son
Address 32 S. Broadway

19. 24 January 1940 (Date rec'd by registrar) Caldwell Woodruff Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 22, 1940, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/10/39 19__, to 1/22/40 19__, and that I last saw h— alive on 1/22/40, 19__.

Immediate cause of death	Cardio Vascular Disease	DURATION
	Heart Failure	
Due to		
Due to	Bronchial Asthma	
Other conditions	Hypertension	
	Stone in Left Kidney	

(Include pregnancy within 3 months of death)

Major findings:
Dt operations
Dt autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Samuel Rubin M. D. or other
Address 203 Calvert St. Date signed 1-24-40
Baltimore

RECEIVED
FEB 5 1940
BUREAU V. S.

0144

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (180)

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Emergency Hospital
Stay in hospital or inst. (yrs., or mos., or days): 5 hours
Stay in this community (yrs., or mos., or days): 5 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anna Arundel
City or town: Galesville Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Rosa Gross

3. (b) Social Security Number

4. Sex: female
5. Color or race: negro
6. (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Cyrus Gross
6 (c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.): March 18, 1882
8. AGE: Years 58 | Months 10 | Days 12 | If less than one day ____ hrs. ____ min.
9. Birthplace: Unknown (Town, county, and state)
10. Usual occupation: House work
11. Industry or business
FATHER
12. Name: Jeff Hawkins
13. Birthplace: Prince George County
MOTHER
14. Maiden name: Unknown
15. Birthplace: "
16. Informant: Benj Brown
Address: Churchton Md
17. (Burial, cremation, or removal. Which?) Date thereof: Feb. 2, 1940 (month) (day) (year)
Cemetery or crematory: Gross Cemetery
Location: Churchton Md.
18. Funeral director: J. A. Hardesty & Son
Address: Galesville Md.
19. 2-1 1940 (Date rec'd by registrar) J. M. Murphy (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jany. 30 1940, at 9 15 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__ to ____ 19__, and that I last saw him alive on Post Mortem Examination
Immediate cause of death: 3rd. degree burns
Due to: of face, both arms chest and back and inhalation
Due to: of smoke and gas fumes when house burned.
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations: None
Of autopsy: None

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 1/30/40
Where did injury occur? Galesville (City or town) A.A. (County) Md (State)
Injured at home, farm, industry, public place (where?): in home
Means of injury: fire Injured at work? no
23. SIGNATURE: John M. Caffy Deputy medical examiner M. D. or other
Address: Annapolis Md Date signed 1/30/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 (T)

RECEIVED
FEB 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

0145

Reg. Dist. No. 25

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 (T)

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Brooklyn (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 14

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: A A Co

City or town: Brooklyn Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No.: Pope St (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Elizabeth L Haegerich

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife: Chas W. H. Haegerich

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec 30 1857

8. AGE: Years	Months	Days	If less than one day
82	-	25	hrs. min.

9. Birthplace: Germany (Town, county, and state)

10. Usual occupation: Housework at home

11. Industry or business

FATHER 12. Name: Charles Marquard

FATHER 13. Birthplace: Germany

MOTHER 14. Maiden name: Don't Know

MOTHER 15. Birthplace: Germany

16. Informant: Mrs Walter J Haegerich

Address: Pope St. Brooklyn Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 27 1940 (month) (day) (year)

Cemetery or crematory: Baltimore

Location: E. North Ave

18. Funeral director: William M Marock

Address: 715 Light St

19. Jan 25 1940 (Date rec'd by registrar) Ida M. Whitem Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 24 1940, at 5:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1939, to Jan 24 1940, and that I last saw her alive on Jan 23, 1940.

Immediate cause of death	DURATION
Arteriosclerosis	many years
Myocardial degeneration	old years
Due to	—
Senility	
Due to	3 days
Terminal Bronchopneumonia	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations: —

Of autopsy: —

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Lawrence M Sena M. D. or other

Address: 1009 Annapolis Blvd Brooklyn Md Date signed: 1.24.40

RECEIVED
JAN 27 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0146

Reg. Dist. No. 24

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Crownsville State Hospital

Stay in hospital or inst. (yrs., or mos., or days): 20 days

Stay in this community (yrs., or mos., or days): -----

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore City Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No.: 933 S. Baylis Street (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: -----

3. (a) FULL NAME: EVA HALL

3. (b) Social Security Number: -------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	black	married

6 (b) Name of husband or wife: XXX John Hall

6(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): 1900

8. AGE: Years	Months	Days	If less than one day
40	Unknown		____ hrs. ____ min.

9. Birthplace: South Carolina (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: ------

FATHER — 12. Name: Jack Jackson

FATHER — 13. Birthplace: South Carolina

MOTHER — 14. Maiden name: Hattie (Unknown)

MOTHER — 15. Birthplace: South Carolina

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 26th 1940 (month) (day) (year)

Cemetery or crematory: Mt Calvery Cemet

Location: Broadneck

18. Funeral director: Edroy O Wilson

Address: 1000 — Brantly Ave

19. 1/24 (Date rec'd by registrar) 19 40 E. T. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 23rd 19 40 at 12:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 3rd, 19 40, to Jan. 23rd 19 40, and that I last saw her alive on January 23rd 19 40.

Immediate cause of death	DURATION
Broncho pneumonia of the right lower lobe	
Due to	
Due to	
Other conditions: General paresis	

(Include pregnancy within 3 months of death)

Major findings:

Of operations: -----

Of autopsy: -----

PHYSICIAN — Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ------ Date of:

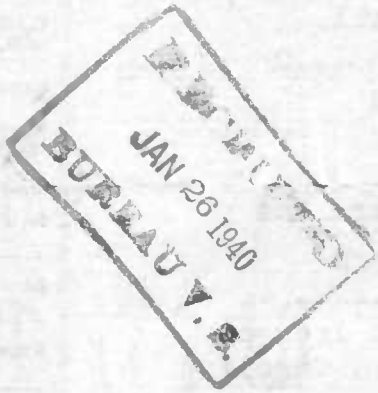
Where did injury occur? ------ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): -----

Means of injury: Injured at work? -----

23. SIGNATURE: Fred S. Armitage M. D. or other

Address: Crownsville, Md. Date signed: 1/23/40


JAN 26 1940
BUREAU V. S.

0147

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Crownsville State Hospital
Stay in hospital or inst. (yrs., or mos., or days): 11 mos. 17 das.
Stay in this community (yrs., or mos., or days): -----

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George's
City or town: Hyattsville Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 18 St. Mary's Street
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: -----

3. (a) FULL NAME: ELMER HARDMAN (ELMER HARDMAN)

3. (b) Social Security Number: No record - OAD

4. Sex: male
5. Color or race: black
6. (a) Single, married, widowed, or divorced: separated
6 (b) Name of ~~husband~~ or wife: Unknown
6(c) If alive, give age: ? years
7. Birth date of deceased (mo., day, yr.): 1909
8. AGE: Years: 31 Months: Unknown Days: If less than one day: hrs. min.
9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: -----
FATHER 12. Name: Eli Hardman
13. Birthplace: Maryland
MOTHER 14. Maiden name: Lena Hardman
15. Birthplace: Maryland
16. Informant: Hospital Records
Address: Crownsville, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 1-22-40 (month) (day) (year)
Cemetery or crematory:
Location: Near Prince Frederick, Md
18. Funeral director: Francis Gasch Sons
Address: Hyattsville, Md.
19. 1/20 1940 (Date rec'd by registrar) E F Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 19th 1940, at 5:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 2nd 1939, to Jan. 19th 1940, and that I last saw him alive on Jan. 19th 1940.

Immediate cause of death: General paralysis of the insane — DURATION
Due to:
Due to: Lues
Other conditions: ~~p~~-----
(Include pregnancy within 3 months of death)
Major findings: ----
Of operations:
Of autopsy: -----

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: ----- Date of:
Where did injury occur? ----- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): -----
Means of injury: Injured at work? -----

23. SIGNATURE: [signature] M. D. or other
Address: Crownsville, Md. Date signed: 1/19/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
FEB 5 1949
BUREAU V. S.

VS A15 (T) MARGIN RESERVED FOR BINDING (M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0148

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Crownsville State Hospital

Stay in hospital or insf. (yrs., or mos., or days): 2 mos. 7 days

Stay in this community (yrs., or mos., or days): 2 mos. 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Prince George

City or town: Unknown Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: William Alexander Hawkins

3. (b) Social Security Number: none

4. Sex: Male

5. Color or race: Black

6. (a) Single, married, widowed, or divorced: Married (separated)

6 (b) Name of husband or wife: Unknown

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): 1885

8. AGE: Years: 54 Months: ? Days: ? If less than one day ____ hrs. ____ min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER
12. Name: Charles E. Hawkins
13. Birthplace: Maryland

MOTHER
14. Maiden name: Nanie Stevenson
15. Birthplace: Maryland

16. Informant: Hospital Records

Address

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: 1-28-40 (month) (day) (year)

Cemetery or crematory: Lincoln Memorial Cemetery

Location: Prince George County

18. Funeral director: J.B. Johnson

Address: Annapolis, Md.

19. 1-27 1940 (Date rec'd by registrar) J. [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 23 1940, at 4:40 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 16, 1939, to Jan. 23, 1940, and that I last saw him alive on Jan. 23 1940.

Immediate cause of death: General Paralysis of the insane — Duration: unknown

Due to: Lues

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings:

Of operations: —

Of autopsy: —

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: —

Accident, suicide, or homicide: — Date of: —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): —

Means of injury: — Injured at work? —

23. SIGNATURE: [illegible] M. D. or other

Address Date signed

RECEIVED
FEB 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

(82-a)

0149

CERTIFICATE OF DEATH

Reg. Dist. No. 21

WITHIN CORPORATE LIMITS OF

1. PLACE OF DEATH:
County A. A.
City or town Annapolis
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Emergency Hosp
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County A. A.
City or town Annapolis Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 72 Pleasant st
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Martha Ellen Hebron

3. (b) Social Security Number

4. Sex Fen
5. Color or race Colored
6. (a) Single, married, widowed, or divorced widow
6 (b) Name of husband ~~or wife~~ Samuel Hebron
6(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Mar. 2 1873

8. AGE: Years 66 Months 10 Days 11 If less than one day hrs. min.

9. Birthplace A. A. (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name Samuel Hebron
13. Birthplace Prince Georges
MOTHER 14. Maiden name Louisa Stewart
15. Birthplace A. A. Co
16. Informant George Hebron
Address 72 Pleasant st
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 17 1940 (month) (day) (year)
Cemetery or crematory Brewer Hill
Location Annapolis Md
18. Funeral director J. B. Johnson
Address Annapolis
19. 1-17 1940 (Date rec'd by registrar) J. J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 13 1940, at 7:57 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 20 1939, to Jan 13 1940, and that I last saw her alive on Jan 12 1940.

Immediate cause of death: Cerebral Hemorrhage — DURATION: Dec 20
Due to: Gen. Arteriosclerosis — ?
Due to
Other conditions: Obesity.
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Maurice F. Klawans, M.D. M. D. or other
Address 31 South Gate av Date signed 1/16/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
FEB 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0150

Reg. Dist. No. 21

1. PLACE OF DEATH:

County A.A.

City or town Annapolis, Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Emergency Hospital

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 79 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County A.A.,

City or town Rural Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. Riva Md.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Joseph T. Higgs

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6 (b) Name of husband or wife Mary S. Higgs

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 6 1860

8. AGE: Years	Months	Days	If less than one day
79	2	7	hrs. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name Joseph Higgs

13. Birthplace Maryland

MOTHER 14. Maiden name Unknown

15. Birthplace Uknown

16. Informant Mrs Thirkell Asquith

Address Riva Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 17 1940 (month) (day) (year)

Cemetery or crematory Hope Chapel

Location South River

18. Funeral director B.L.Hopping

Address Annapolis, Md.

19. 1 17 1940 (Date rec'd by registrar) J.J.Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 13 1940, at 8 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 31 1939, to January 13 1940, and that I last saw him alive on January 13 1940.

	DURATION
Immediate cause of death Lobar Pneumonia	2 weeks
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Walton H Hopkins M.D.
M. D. or other

Address Annapolis Md Date signed 1-16-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
FEB 5 1940
BUREAU V. S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

0151

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

V. S. No. 1

1. PLACE OF DEATH (83-a)

County Anne Arundel Registration Dist. No.

Village or City Mayo No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U.S. if of foreign birth? 65 yrs. mos. ds.

2. FULL NAME Henry Frederick Himburg If U. S. Veteran, specify WAR

(a) Residence: No. Mayo St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Thelma Baker Himburg

6. DATE OF BIRTH (month, day, and year) July 29 - 1865

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	5	14	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Merchant & Postmaster

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year) Dec 27/39 11. Total time (years) spent in this occupation 50

12. BIRTHPLACE (city or town) Himburg Germany (State or country)

FATHER

13. NAME Henry Frederick Himburg

14. BIRTHPLACE (city or town) Germany (State or country) alsatia

MOTHER

15. MAIDEN NAME Marie Schosming

16. BIRTHPLACE (city or town) Germany (State or country) alsatia

17. INFORMANT Thelma Baker Himburg (Address) mayo md

18. BURIAL, CREMATION, OR REMOVAL Place mayo Date Jan 16, 1940

19. UNDERTAKER Robert G. Suite (Address) 829 West St

20. FILED Jan 14, 1940 Edw Collinson Assistant Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Jan. 12 (Month) (Day), 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from Dec. 28, 1939, to Jan. 11, 1940

I last saw him alive on Jan 11, 1940; death is said to have occurred on the date stated above, at 7:25 A.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Cerebral hemorrhage	12-28-39
Generalized arteriosclerosis	?

Other Contributory Causes of importance:

Name of operation none Date of

What test confirmed diagnosis? none Was there an autopsy? no

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) W. F. Findlay M. D.

(Address) Davidsonville, Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and **own home** in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel,** etc. For a person who had no occupation whatever write **none.**

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver,** etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill,** etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer,** etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist,** etc. Distinguish carefully between **retail merchants** and **wholesale merchants.** A person who sells goods should be called a **salesman** and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (106-a)

0152

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County A. A.
City or town Carleigh Heights
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County A. A.
City or town Carleigh Heights Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Sarah Hughes

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem	Colyer	married

6 (b) Name of husband or wife Robert Hughes
6(c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) Dec. 17 1890

8. AGE: Years	Months	Days	If less than one day
49	1	12	hrs. min.

9. Birthplace Carleigh Heights A. A. (Town, county and state)
10. Usual occupation Housework
11. Industry or business

FATHER
12. Name Thomas F. Jennings
13. Birthplace A. A.

MOTHER
14. Maiden name Georgianna Dotson
15. Birthplace A. A.

16. Informant Johnson Glenn Jr.
Address Carleigh Heights

17. Burial Date thereof Feb. 2 1940
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Town neck Cem.
Location a. a. Co., Md.

18. Funeral director J. B. Johnson
Address Annapolis, Md.

19. 1-29 19 40 L. A. Breit
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 29 1940, at 9.45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1937 to Jan. 29 1940
and that I last saw h[illegible] alive on Jan. 29 1940

Immediate cause of death Respiratory paralysis — DURATION 2 Days
Due to Myasthenia gravis 3 Yrs.
Due to
Other conditions acute Bronchitis 2 Days.
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE L. A. Breit M.D.
M. D. or other
Address Pasadena, Md. Date signed 1-29-40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
FEB 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0153

Reg. Dist. No. 221

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Jessup, Maryland.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Maryland House of Correction

Stay in hospital or inst. (yrs., or mos., or days): 16 days

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland. County:

City or town: Baltimore, Md. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: unknown
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Leon Inloes

3. (b) Social Security Number: No record - OAD

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col'd	Single

B (b) Name of husband or wife: None

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 1st, 1894

8. AGE: Years	Months	Days	If less than one day
45	11	20	5 hrs. min.

9. Birthplace: Baltimore, Maryland.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER
12. Name: John Inloes
13. Birthplace: unknown

MOTHER
14. Maiden name: Jennie Parker
15. Birthplace: unknown

16. Informant: Records of Md House of Correction
Address: Jessup. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jany 30 - 40 (month) (day) (year)

Cemetery or crematory: Cherry Hill

Location: Jessup Md

18. Funeral director: N. L. Collins.

Address: Jessup Md.

19. Jan 29 1940 (Date rec'd by registrar) Clara M. Haslup. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 21st, 1940, at 5. A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 6th 1940, to January 21 1940, and that I last saw him alive on January 21st, 1940.

Immediate cause of death	DURATION
Acute Myocarditis	15 days
Due to Chronic Nephritis	"
Due to Latent syphilis	Unknown
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Thos. H. Phillips M. D. or other

Address: Maryland House of Correction, Jessup, Maryland. Date signed

RECEIVED
FEB 6 1940
BUREAU V. S. .

0155

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48-B)

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Crownsville State Hospital

Stay in hospital or inst. (yrs., or mos., or days): 7yr. 2mo. 24days

Stay in this community (yrs., or mos., or days): 7yr. 2mo. 24days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore City

City or town: Baltimore City Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 1409 Bruhl Street
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: ---

3. (a) FULL NAME: Ella Jackson

3. (b) Social Security Number: ---

4. Sex: Female

5. Color or race: Black

6. (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Unknown

6(c) If alive, give age: --- years

7. Birth date of deceased (mo., day, yr.): 1861

8. AGE: Years: 79 Months: Unknown Days: If less than one day: -- hrs. ---- min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: ---

FATHER
12. Name: Thomas Jones
13. Birthplace: Maryland

MOTHER
14. Maiden name: Tiny Greene
15. Birthplace: Maryland

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/20-40 (month) (day) (year)

Cemetery or crematory: Hospital

Location: Crownsville

18. Funeral director: Supt

Address

19. 1/20-40 (Date rec'd by registrar) 19 E. F. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 13, 1940, at 10:15 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 19 1932, to January 13 1940, and that I last saw her alive on January 13 1940.

Immediate cause of death: Carcinoma of the Uterus

Due to: ---

Due to: ---

Other conditions: ---
(Include pregnancy within 3 months of death)

Major findings:

Of operations: ---

Of autopsy: ---

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: --- Date of: ---

Where did injury occur? ---- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ---

Means of injury: --- Injured at work? ---

23. SIGNATURE: [signature] M. D. or other

Address: Crownsville, Md. Date signed: 1/13/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
FEB 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0154

Reg. Dist. No. 22

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Odenton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 30 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Anne Arundel
City or town: Odenton Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: —
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: —

3. (a) FULL NAME: Virginia Jackson

3. (b) Social Security Number: None

4. Sex: F W
5. Color or race:
6. (a) Single, married, widowed, or divorced:
6 (b) Name of husband or wife: James A. Jackson Sr.
6(c) If alive, give age ___ years
7. Birth date of deceased (mo., day, yr.): Nov. 2nd 1858.

8. AGE: Years: 82 Months: 2 Days: 26 If less than one day ___ hrs. ___ min.

9. Birthplace: Howard Co Md (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: Thos. Selby
13. Birthplace: Md
MOTHER 14. Maiden name: Unknown
15. Birthplace:
16. Informant: Jas A Jackson
Address: Odenton Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 31 1940. (month) (day) (year)
Cemetery or crematory: Mt. Olivet
Location: Baltimore Md
18. Funeral director: Lloyd Kaiser
Address: Laurel Md.
19. Jan 29 1940 (Date rec'd by registrar) W. L. Jones D.L. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 28 1940, at 8 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 6 1940, to Jan 28 1940, and that I last saw her alive on Jan 27 1940.
Immediate cause of death: Acute Cardiac Failure
Due to:
Due to:
Other conditions: Asterosclerosis and Chronic Myocarditis
(Include pregnancy within 3 months of death)
Major findings:
Of operations:
Of autopsy:

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Jos E. Lipskey M. D. or other
Address: Odenton Md Date signed: Jan 28-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
FEB 8 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0156

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Crownsville State Hospital

Stay in hospital or inst. (yrs., *or* mos., *or* days): 10 mos. 24 dys.

Stay in this community (yrs., *or* mos., *or* days): ------

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: ------

City or town: Baltimore City Ward No. ------

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 1300 Penna Avenue

(If rural give LOCATION)

2(*a*) IF VETERAN, NAME WAR: ------

3. (*a*) FULL NAME: CAROLINE JOHNSON alias CARRIE WOODWARD

3. (*b*) Social Security Number: ------

4. Sex	5. Color or race	6.(*a*) Single, married, widowed, or divorced
Female	black	widowed

6 (*b*) Name of husband or wife: Unknown

6(*c*) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.): 1893 (?)

8. AGE:

Years	Months	Days	If less than one day
47 ?	Unknown		------ hrs. ------ min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: ------

FATHER — 12. Name: John Woodward

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Caroline (Unknown)

15. Birthplace: Maryland

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 23 40 (month) (day) (year)

Cemetery or crematory: Mt. Auburn

Location: Balto. Md.

18. Funeral director: Mrs. George H. Holland

Address: 1631 Druid Hill Ave

19. Jan 16 (Date rec'd by registrar) 1940 J. E. T. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 16th 1940, at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Feb. 23rd, 1939, to Jan. 16 1940, and that I last saw her alive on Jan. 16th 1940.

Immediate cause of death	DURATION
Lobar pneumonia	
Due to	
Due to	
Other conditions: General paresis	

(Include pregnancy within 3 months of death)

Major findings: ------

Of operations: ------

Of autopsy: ------

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ------ Date of: ------

Where did injury occur? ------ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ------

Means of injury: ------ Injured at work?

23. SIGNATURE: Frank J. Thweatt M. D. or other

Address: Crownsville, Md. Date signed: 1/16/40

RECEIVED
FEB 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

30-6

0157

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Crownsville State Hospital

Stay in hospital or inst. (yrs., or mos., or days): 22 days.

Stay in this community (yrs., or mos., or days): -----

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Talbot

City or town: Easton Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Unknown - Route 1
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: -------

3. (a) FULL NAME: EDWARD JOHNSON #3

3. (b) Social Security Number: ------

4. Sex: male

5. Color or race: black

6. (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Bertie Johnson

6(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): 1880

8. AGE: Years: 60 Months: Unknown Days: If less than one day: ____ hrs. ____ min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Farm laborer

11. Industry or business: General

FATHER
12. Name: James Johnson
13. Birthplace: Maryland

MOTHER
14. Maiden name: Georgiana Askins
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. burial (Burial, cremation, or removal. Which?) Date thereof: 1/14, 40 (month) (day) (year)

Cemetery or crematory: Hospital Cemetery

Location: Crownsville Md.

18. Funeral director: Supt
Address: Crownsville Md

19. 1/17, 1940 (Date rec'd by registrar) E. F. Joyce DL Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 7th 1940, at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 14th 1939, to Jan. 7th 1940, and that I last saw him alive on January 7th 1940.

Immediate cause of death: General paralysis of the insane

DURATION

Due to

Due to: Lues

Other conditions: ----------
(Include pregnancy within 3 months of death)

Major findings: ------

Of operations

Of autopsy: ------

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: ---- Date of

Where did injury occur? ------ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ---------

Means of injury: ---- Injured at work?

23. SIGNATURE: Herb P. Mintrodes M. D. or other

Address: Crownsville, Md. Date signed: 1/7/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
FEB 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (121-a)

0158
2)

CERTIFICATE OF DEATH

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address (hospital or institution): 97 Calvert St.
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 70 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Annapolis Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 97 Calvert st.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Jane Johnson
3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col.	widow

6 (b) Name of husband ~~or wife~~ Charles S. Johnson deceased
6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) June 22, ~~1864~~ 1870

8. AGE Years	Months	Days	If less than one day
~~75~~ 69 ~~75~~ 69	6	3	hrs. min.

9. Birthplace Anne Arundel Co. Annapolis Md.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name unknown
13. Birthplace unknown

MOTHER
14. Maiden name unknown
15. Birthplace unknown

16. Informant Elizabeth Johnson
Address 97 Calvert

17. (Burial, ~~cremation, or removal. Which?~~) Date thereof 1/7/40 (month) (day) (year)
Cemetery or crematory Brewer Hill
Location Dr. Washington rd. outside Annapolis Md.
18. Funeral director Chas. F. Alexander
Address 43 45 Northwest st. Annapolis Md

19. Jan 6 1940 (Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 3 1940, at 1:15 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 7th 1939, to January 3 1940, and that I last saw her alive on January 3 1940

Immediate cause of death	DURATION
Cardio - Renal Disease	3
Due to	
Due to	
Other conditions	
(Include pregnancy within 3 months of death)	
Major findings:	
Of operations	
Of autopsy	

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide / Date of /
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury / Injured at work? ~

23. SIGNATURE Lawrence W. Greene, M.D.
M. D. or other
Address Annapolis, Md. Date signed 1/5/40

JAN 27 1940
BUREAU V. S.

DR. J. J. MURPHY
RANDALL AND KING GEORGE STREETS, ANNAPOLIS, MARYLAND
TELEPHONE 234 CONSULTATIONS: 9 TO 10:30 A.M., 1:30 TO 3 AND 6 TO 7 P.M. REG. NO. 827

℞ For

Address Date

METRIC

James Johnson was
born June 22 1870 + is
69-yrs 6M 3 days old. I
made a mistake on the
death certificate — James
Johnson to my mother
Elizabeth Johnson

DeCONWAY
PHARMACY

Informant M. D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (122-a)

0159

CERTIFICATE OF DEATH

Reg. Dist. No. 22

1. PLACE OF DEATH:

County: Anne Arundel

City or town: (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Odenton

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 60 years

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: Anne Arundel

City or town: Odenton Ward No.: (If outside city or town limits, write RURAL NEAR and give town)

Street No.: (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: none

3. (a) FULL NAME: Jeremiah Jones

3. (b) Social Security Number: None

4. Sex: Male

5. Color or race: W

6. (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Dena Jones

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan 1 - 1853

8. AGE: Years: 87 Months: — Days: 2 If less than one day: hrs. min.

9. Birthplace: Anne Arundel Co (Town, county, and state) Md

10. Usual occupation:

11. Industry or business:

FATHER 12. Name: Unknown

13. Birthplace:

MOTHER 14. Maiden name: Unknown

15. Birthplace:

16. Informant: W. F. Jones

Address: Odenton Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jany 6-1940 (month) (day) (year)

Cemetery or crematory: Nicols Memorial

Location: Odenton Md

18. Funeral director: Thos. J. Tickner & Son

Address: Baltimore Md

19. Jan 3 1940 (Date rec'd by registrar) W. L. Jones D.L. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 3 1940, at 1:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 2 1940 to Jan 3 1940, and that I last saw him alive on Jan 2 1940.

Immediate cause of death: Acute Cardiac Failure — DURATION

Due to:

Due to: Strangulated Hernia

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations: X

Of autopsy:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: John B. Lipsky M. D. or other

Address: Odenton Md Date signed: Jan 3 - 1940

RECEIVED
FEB 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

0160

CERTIFICATE OF DEATH

Reg. Dist. No. 2-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Eastport
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 520 Third St.
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Anne Arundel
City or town: Eastport Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 520 Third St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Julia Anna Kelly

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife: Levin P. Kelly
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 17th 1870

8. AGE:

Years	Months	Days	If less than one day
69	9	28	hrs. min.

9. Birthplace: Annapolis Md.
(Town, county, and state)
10. Usual occupation: House wife
11. Industry or business:
FATHER 12. Name: Peter C Hara
13. Birthplace: Ireland
MOTHER 14. Maiden name: Frances Campbell
15. Birthplace: Annapolis Md.
16. Informant: Elizabeth Tankersley
Address: Eastport Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jany 17-1940 (month) (day) (year)
Cemetery or crematory: Cedar Bluff
Location: Annapolis Md
18. Funeral director: John M. Taylor
Address: Annapolis Md.
19. 1/16 1940 (Date rec'd by registrar) J. J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1-14 1940, at 3A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1937, to Jan 14 1940, and that I last saw her alive on Jan 14 1940.

Immediate cause of death	DURATION
Myocarditis Chronic	3 years
Myocardial Insufficiency	3 years
Due to Arteriosclerosis	unknown
Due to Chr Bronchitis	unknown
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: George C Bond
M. D. or other
Address: Annapolis Md Date signed 1-15-40

RECEIVED
FEB 5 1940
BUREAU V. S.

M. D. B. 1268-9

State of Maryland

HEALTH DEPARTMENT—~~CITY OF BALTIMORE~~

0161

CERTIFICATE OF DEATH (940)

1. PLACE OF DEATH

Registered No. 2623

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Anne Arundel County
~~CITY OF BALTIMORE~~: (No. Riveria Beach St., Ward)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Robert Kraft

(a) Residence: No. Riveria Beach St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. Color or Race: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Virginia Kraft

6. DATE OF BIRTH (month, day, year): Feb-2-1877

7. AGE: Years 63, Months 10, Days 25. If LESS than 1 day, hrs. or min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.: Mechanic
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.: Elevator
10. Date deceased last worked at this occupation (month and year): Dec-1933
11. Total time (years) spent in this occupation: 20

12. BIRTHPLACE (city or town) (State or country): Baltimore Md

FATHER
13. NAME: Henry P. Kraft
14. BIRTHPLACE (city or town) (State or country): Baltimore Md

MOTHER
15. MAIDEN NAME: Wilson
16. BIRTHPLACE (city or town) (State or country): Baltimore Md

17. INFORMANT (Address): William Kraft, 1619 W. Pratt

18. BURIAL, CREMATION, OR REMOVAL
Place: National Cemetery Date: Jan 29, 1940

19. UNDERTAKER (Address): A. Jones, 111 S. Selmor St.

20. FILED: Jan. 25, 1940 Mr. DeAlba Dep. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year): Jan-25, 1940

22. I HEREBY CERTIFY, That I attended deceased from Jan-25, 1940, to Jan-25, 1940
I last saw him alive on Jan-25, 1940. Death is said to have occurred on the date stated above, at 3 A m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Coronary Thrombosis	1/25/40

Other contributory causes of importance:

Name of operation: Date of:

What test confirmed diagnosis? none Was there an autopsy? no

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? Date of injury, 19
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place
Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased? ? If so, specify

(Signed) [signature] M. D.
(Address) 320 Patapsco Ave
Balto. Md

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. 3

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as *at school* or *at home*. For a woman whose only occupation was that of home housework, write *housewife* in answer to Question 8 and *own home* in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as *servant—private family, cook—hotel*, etc. For a person who had no occupation whatever write *none*.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as *spinner, weaver*, etc.

In stating the industry or business avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as *grocery store, soap factory, cotton mill*, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as *civil engineer, mechanical engineer, mining engineer, stationary engineer*, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give exact occupation, as *carpenter, painter, machinist*, etc. Distinguish carefully between *retail merchants* and *wholesale merchants*. A person who sells goods should be called a *salesman* and not a *clerk*.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, *not* the mode of dying, *e. g.*, heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

M. D. B. 1268-9

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0162

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Crownsville State Hospital
Stay in hospital or inst. (yrs., or mos., or days): 9 yrs. 1 mo. 6 das.
Stay in this community (yrs., or mos., or days): -----

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore City Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 524 Wilson St.,
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: -----

3. (a) FULL NAME: HELEN MACKEY

3. (b) Social Security Number: -------

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	black	Unknown

6 (b) Name of husband or wife: Unknown
6(c) If alive, give age: Unknown years
7. Birth date of deceased (mo., day, yr.): 1892

8. AGE: Years	Months	Days	If less than one day
48	Unknown		hrs. min.

9. Birthplace: Unknown (Town, county, and state)
10. Usual occupation: Unknown
11. Industry or business: Unknown
FATHER 12. Name: Unknown
13. Birthplace: Unknown
MOTHER 14. Maiden name: Unknown
15. Birthplace: Unknown
16. Informant: Hospital Records
Address: Crownsville, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 2/12-40 (month) (day) (year)
Cemetery or crematory: Hospital
Location: Crownsville Md
18. Funeral director: Supt.
Address:
19. 2/12- 1940 (Date rec'd by registrar) E. F. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 29th 1940, at 7:40 PM
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 23rd 1930, to Jan. 29th 1940, and that I last saw her alive on Jan. 29th 1940.

Immediate cause of death: Lobar pneumonia (upper right lobe and left base)
DURATION:
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings:
Of operations: ------
Of autopsy: ------

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ----- Date of:
Where did injury occur? ------ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ------
Means of injury: ---- Injured at work? -----

23. SIGNATURE: [signature] M. D. or other
Address: Crownsville, Md. Date signed: 1/29/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAR 5 1940
BUREAU V. S.

0163

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (181)

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Harmons. P.O. Md
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Dorsey Road
Stay in hospital or inst. (yrs., or mos., or days): —
Stay in this community (yrs., or mos., or days): 18 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Harmons Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: Dorsey Rd
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: John Mahaley

3. (b) Social Security Number: none.

4. Sex: male
5. Color or race: white
6. (a) Single, married, widowed, or divorced: not known
6 (b) Name of husband or wife: not known
6(c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.): not known
8. AGE: about Years 80 Months Days If less than one day ____ hrs. ____ min.
9. Birthplace: Austria (Town, county, and state)
10. Usual occupation: farm laborer
11. Industry or business: General farming
FATHER
12. Name: not known
13. Birthplace: " "
MOTHER
14. Maiden name: not known
15. Birthplace: " "
16. Informant: Mr. J. Hawkins
Address: Harmons. Md
17. BURIAL (Burial, cremation, or removal. Which?) Date thereof: JAN 23 1940 (month) (day) (year)
Cemetery or crematory: FRIENDSHIP
Location: A A Co
18. Funeral director: Wm J Lickner & Sons
Address: North & Pa ans
19. Jan 22 1940 (Date rec'd by registrar) M. R. DeAlba Dep. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: probably Jany. 21 1940, at not known M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__, to ____ 19__, and that I last saw him alive on ____ 19__.
Post mortem exam.
Immediate cause of death: 3rd degree Burns of chest and back to waist line and left hand and forearm
Due to: Fire caught bed clothing
Due to: from lantern
Other conditions: (Include pregnancy within 3 months of death)
Major findings:
Of operations: none
Of autopsy: none

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of: probably Jany. 21, 40
Where did injury occur? Harmons (City or town) A.A. (County) Md (State)
Injured at home, farm, industry, public place (where?): at home
Means of injury: fire Injured at work? no.
23. SIGNATURE: John M. Claffy Deputy medical examiner. M. D. or other
Address: Annapolis. Md Date signed: 1/22/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

I (T)

RECEIVED
FEB 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (160-G)

0164

CERTIFICATE OF DEATH

WITHIN CORPORATE LIMITS OF

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis Maryland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 43 Washington St - Annapolis Md
Stay in hospital or inst. (yrs., or mos., or days): 1 day;
Stay in this community (yrs., or mos., or days): 1 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Annapolis md County: a-a-
City or town: Annapolis Md Ward No. 4
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 43 Washington St Annapolis Md
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: None

3. (a) FULL NAME: Charles Makell.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male.	Colord	Single

6 (b) Name of husband or wife: None

6(c) If alive, give age: None years

7. Birth date of deceased (mo., day, yr.): Jan - 20 1940

8. AGE:

Years	Months	Days	If less than one day
0 ~~1940~~	0	7	7 days hrs. min.

9. Birthplace: Annapolis Anne Arundel Co. Md (Town, county, and state)

10. Usual occupation: None.

11. Industry or business: None.

FATHER
12. Name: Leon Makell
13. Birthplace: Annapolis Maryland.

MOTHER
14. Maiden name: Louisa Haste.
15. Birthplace: Annapolis Maryland.

16. Informant: Leon Makel.
Address: 43 Washington St -

17. Burial, cremation, or removal. Which?: Brewerhill Cemt - Date thereof: Jan-29-1940 (month) (day) (year)
Cemetery or crematory: Brewerhill Cemt.
Location: West Street, Extd -

18. Funeral director: E. H. B. Parker
Address: 47 Washington St -

19. 1 29 1940 (Date rec'd by registrar) J. J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 27 1940, at 4 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 26 1940, to Jan 27 1940, and that I last saw h[illegible] alive on Jan 26 1940

Immediate cause of death	DURATION
Cerebral Hemorrhage	1 hr.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Ot operations:
Ot autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: George C Boul M. D. or other
Address: Annapolis Md Date signed 1-29-40

Dr Basil

RECEIVED
FEB 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0165

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Crownsville State Hospital

Stay in hospital or inst. (yrs., or mos., or days): 2 yrs. 3 mos. 14 ds

Stay in this community (yrs., or mos., or days): " " "

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Prince George

City or town: Rural Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Riggs Road
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Brodie McDonald

3. (b) Social Security Number

4. Sex: Male

5. Color or race: Black

6. (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Unknown

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): ? ? 1862

8. AGE: Years: 77 Months: ? Days: ? If less than one day ____ hrs. ____ min.

9. Birthplace: Fredericksburg, Va.
(Town, county, and state)

10. Usual occupation: Minister

11. Industry or business

FATHER
12. Name: Edward McDonald
13. Birthplace: Unknown

MOTHER
14. Maiden name: Lucy ?
15. Birthplace: Unknown

16. Informant: Oliver H. McDonald, Nephew

Address: 4925 Blaine St. N.E. Washington, D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 1-10-40 (month) (day) (year)

Cemetery or crematory: Lincoln Cemetery

Location: Washington, D.C.

18. Funeral director: John T. Rhines

Address: Washington, D.C.

19. 1/7 1940 (Date rec'd by registrar) E. F. Joyce D.L. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 6 1940, at 8 45 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 22 1937, to Jan. 6 1940, and that I last saw him alive on Jan. 6 1940.

Immediate cause of death: Chronic Myocarditis. — DURATION: Unknown

Due to

Due to

Other conditions: Senile Psychosis — Unknown
(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: Joseph P. Wm Erodz
M. D. or other

Address ____ Date signed ____

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

JAN 19 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0166

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 38 Franklin St.

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: A. A. Co.

City or town: Annapolis Ward No. 3
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 38 Franklin St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: WILLIAM L. MEREDITH

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife: Virginia A. Meredith

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 28, 1851

8. AGE: Years	Months	Days	If less than one day
88	7	16	hrs. min.

9. Birthplace: King & Queen Co. Virginia
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER
12. Name: Miles C. Meredith
13. Birthplace: King & Queen Co. Virginia

MOTHER
14. Maiden name: Frances A. Roane
15. Birthplace: King & Queen Co. Virginia

16. Informant: Carey L. Meredith

Address: Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof JAN'Y-15-1940 (month) (day) (year)

Cemetery or crematory: Gloucester Co. Va.

Location:

18. Funeral director: John M. Taylor

Address: Annapolis, Md.

19. 1 14 19 40 (Date rec'd by registrar) J. M. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 13th 1940, at 1:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 10th 1939 to Jan 13 1940 and that I last saw h-im alive on Jan 12 1940.

Immediate cause of death: Uraemia -

Due to: C. Nephritis +

Due to: Arterio Sclerosis & Arterial Hypertension

Other conditions: Left Side Hemiplegia 3 yrs Duration

(Include pregnancy within 3 months of death)

DURATION: 24 hrs. Rural yrs.

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Odion Powers M. D. or other

Address: Annapolis Md. Date signed 1/13/40

RECEIVED
FEB 5 1940
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(159)

0167

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County A.A.

City or town Annapolis,
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Emergency Hospital

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County A.A.

City or town Rural Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. Arnolds, Md.
(If rural give LOCATION)

2(o) IF VETERAN, NAME WAR

3.(a) FULL NAME Baby Murphy

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 13 1940

8. AGE: Years | Months | Days | If less than one day 1 hrs. min.

9. Birthplace Annapolis, Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name James J. Murphy Jr
13. Birthplace Eastport, Md.

MOTHER
14. Maiden name Ethel A. Fox
15. Birthplace Baltimore, Md.

16. Informant James J. Murphy Jr
Address Arnolds, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan15 1940 (month) (day) (year)

Cemetery or crematory St. Marys

Location Annapolis, Md.

18. Funeral director B.L.Hopping
Address Annapolis, Md.

19. 1-13 1940 (Date rec'd by registrar) J J Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 13 1940, at 3:10 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 13 1940, to Jan 13 1940, and that I last saw her alive on Jan. 13 1940.

Immediate cause of death Prematurity (6 mos)

DURATION 6th mo Gestation

Due to Unknown

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M. F. Klawans, M.D. M. D. or other

Address 31 Smithgate Av Date signed 1/13/40

RECEIVED
FEB 5 1940
BUREAU V. S.

0168

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-C)

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Eastport
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 420 Sixth St.

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 63 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Eastport Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 420 Sixth St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: No

3. (a) FULL NAME: HORACE J. NORWOOD

3. (b) Social Security Number: None Employed by county.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife: Agnes Norwood

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 8, 1876

8. AGE: Years	Months	Days	If less than one day
63	10	17	hrs. min.

9. Birthplace: Annapolis, Md.
(Town, county, and state)

10. Usual occupation: Keeper of Eastport Bridge

11. Industry or business:

FATHER
12. Name: William Norwood
13. Birthplace: Annapolis, Md.

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Horace J. Norwood Jr.
Address: Eastport, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jany 27, 1940 (month) (day) (year)

Cemetery or crematory: St. Mary's Cemetery
Location: Annapolis, Md.

18. Funeral director: John M. Taylor
Address: Annapolis, Md.

19. 1 25 (Date rec'd by registrar) 1940 J J Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 27, 1940, at 1:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 1, 1939, to Jan. 28 1940, and that I last saw him alive on January 25, 1940.

Immediate cause of death:
1) Acute dilatation of Heart
2) Hypertrophy of Heart
3) Chronic Interstitial Nephritis

Due to: (Unknown Cause)

Other conditions:
(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy: No

DURATION
Quiz-dead
2 months
2 months

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Albert L. Anderson M. D. or other
Address: Annapolis, Md. Date signed: 1/25/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
FEB 5 1940
BUREAU V. S.

0169

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Crownsville State Hospital

Stay in hospital or inst. (yrs., or mos., or days): 2 mos. 4 days

Stay in this community (yrs., or mos., or days): -----

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore City Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 2210 Pennsylvania Avenue
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: -----

3. (a) FULL NAME: CLAIRBORNE PACK

3. (b) Social Security Number: ------

4. Sex: female

5. Color or race: black

6. (a) Single, married, widowed, or divorced: married

6 (b) Name of husband: James Packs

6 (c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): 1892

8. AGE: Years: 48 Months: Unknown Days: If less than one day: ___ hrs. ___ min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Unknown

11. Industry or business: ---

FATHER
12. Name: Henry Richardson
13. Birthplace: Maryland

MOTHER
14. Maiden name: Ella Brown
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: Jan. 18 40
(month) (day) (year)

Cemetery or crematory: Mt Auburn

Location: Baltimore City

18. Funeral director: Thomas E. Kelson

Address: 1303 Pressman St

19. 1/18-40 19 E. F. Joyce
(Date rec'd by registrar) D.E. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 17th 1940, at 9:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 13th 1939, to Jan. 17 1940 and that I last saw her alive on Jan. 17th 1940

Immediate cause of death: Cerebral hemorrhage based on syphilis

Due to:

Due to: Lues

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations: -----

Of autopsy: ------

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ---- Date of:

Where did injury occur? ---- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): -----

Means of injury: Injured at work? ----

23. SIGNATURE: [signature] M.D. or other

Address: Crownsville, Md. Date signed: 1/17/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

JAN 21 1940
U.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (W)

CERTIFICATE OF DEATH

0170

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Crownsville State Hospital

Stay in hospital or inst. (yrs., or mos., or days): 12 days

Stay in this community (yrs., or mos., or days): ------

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: -

City or town: Baltimore City Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 115 West 22nd St.,
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: --------

3. (a) FULL NAME: WILLIAM PAGE

3. (b) Social Security Number: 157-01-6530 Poss.

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
male	black	widowed

6 (b) Name of husband or wife: Unknown

6(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): 1875

8. AGE: Years: 65 Months: Unknown Days: If less than one day: ____ hrs. ____ min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: General

FATHER
12. Name: Wilson Page
13. Birthplace: Virginia

MOTHER
14. Maiden name: Julia (Unknown)
15. Birthplace: Virginia

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 1-27-40 (month) (day) (year)

Cemetery or crematory: Mount Auburn Cemetery

Location: Baltimore, Md.

18. Funeral director: Mrs. Samuel T. Hemsley

Address: 578 W. Biddle St. Baltimore, Md.

19. 1/24 1940 (Date rec'd by registrar) E. T. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 22nd 1940, at 7:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 10th 1940, to Jan; 22nd 1940, and that I last saw him alive on Jan. 22nd 1940.

Immediate cause of death: Left hemiplegia - diabetic coma

DURATION

Due to

Due to

Other conditions: ------

(Include pregnancy within 3 months of death)

Major findings:

Of operations: ------

Of autopsy: ------

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ----- Date of

Where did injury occur? ----- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ------

Means of injury: Injured at work? ------

23. SIGNATURE: [signature] M. D. or other

Address: Crownsville, Md. Date signed: 1/22/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(M) (T)

RECEIVED
FEB 5 1940
BUREAU V. S.

0171

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 161-a

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH:

County Anne Arundel

City or town Harwood Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County A. A. Co

City or town Harwood Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Donald Steven Parker

3. (b) Social Security Number None

4. Sex: M

5. Color or race: Col

6. (a) Single, married, widowed, or divorced

B (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 3, 1940

8. AGE: Years | Months | Days 2 | If less than one day hrs. min.

9. Birthplace A. A. Co. Maryland
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name Wilson Parker
13. Birthplace Harwood

MOTHER
14. Maiden name Margaret Parker
15. Birthplace Baltimore Md

16. Informant Wilson Parker
Address Harwood

17. (Burial, cremation, or removal. Which?) Date thereof Jan. 5, 1940 (month) (day) (year)

Cemetery or crematory Daniel Stan

Location

18. Funeral director T. A. Hardesty & Son
Address Galesville, Md

19. 1/5/40 19 (Date rec'd by registrar) W. R. Clayton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 5 1940, at 5 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 4 1940, to Jan 5 1940, and that I last saw him alive on Jan 4 1940.

Immediate cause of death Gen Debility

Due to Lack of prenatal care

Due to Aspirated fluid

Other conditions
(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE F B West M. D. or other

Address Lothian, Md Date signed 1/5/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
FEB 6 1940
BUREAU V. S.

0172

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 30-6

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Crownsville State Hospital

Stay in hospital or inst. (yrs., or mos., or days): 2 yrs. 17 das.

Stay in this community (yrs., or mos., or days): -----

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Baltimore City Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 717 Pierce Street
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: -------

3. (a) FULL NAME: VIRGINIA PETTIS

3. (b) Social Security Number: -------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	married

6 (b) Name of husband or wife: George Pettis

6(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): 1907

8. AGE:

Years	Months	Days	If less than one day
32	Unknown		hrs. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: -----

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 1. 13 40 (month) (day) (year)

Cemetery or crematory: Mt Calvary

Location: A. A. County Md

16. Funeral director: William A Jackson

Address: 916 Penna ave

19. 1/10-40 (Date rec'd by registrar) 19 E F Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 9th 1940, at 5:20 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from A.M Dec. 23rd, 1937, to Jan. 9th 1940, and that I last saw her alive on Jan. 9th 1940.

Immediate cause of death: General paralysis of the insane

Due to:

Due to: Lues

Other conditions: -------
(Include pregnancy within 3 months of death)

Major findings:
Of operations: -------

Of autopsy: -------

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ----- Date of:

Where did injury occur? ------- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): -------

Means of injury: ------- Injured at work?

23. SIGNATURE: Herb L. Knutsvedt M. D. or other

Address: Crownsville, Md. Date signed: 1/9/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
FEB 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (1940) Reg. Dist. No. 7-6

CERTIFICATE OF DEATH

0173

1. PLACE OF DEATH:
(a) County Anne Arundel
(b) City or town Patapsco (If outside city or town limits, write RURAL and give town) N. Linthicum
(c) Street address, hospital, or institution Patapsco Rd.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Patapsco, Linthicum Hghts P.O. (If outside city or town limits, write RURAL and give town)
(d) Street No. Patapsco Road (If rural give location)
(e) If foreign born, how long in U. S. A.? — years

3 (a) FULL NAME Mary J. Pruneci

3 (b) If veteran, name war —

3 (c) Social Security No. —

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Bruno Pruneci

6. (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) Feb 22. 1872

8. AGE: Years 67 | Months 10 | Days 25 | If less than one day ____hr. ____min.

9. Birthplace New Jersey (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Home

FATHER
12. Name John Henry
13. Birthplace New Jersey

MOTHER
14. Maiden Name Mary Walterwalks
15. Birthplace New Jersey

16 (a) Informant Bruno Pruneci
(b) Address Patapsco Md Linthicum Hghts

17 (a) ____ (Burial, cremation, or removal) (b) Date thereof Jan 20. 1940 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Holy Redeemer
Location Baltimore Rd. Balto

18 (a) Funeral director Johan A. Maran.
(b) Address 3000 E. Baltimore St.

19 (a) 18 Jan 1940 (Date rec'd by registrar) (b) Caldwell Woodward Registrar

MEDICAL CERTIFICATION

20. Date of death January 17 1940, at 4 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from ____19____, to ____19____, and that I last saw him alive on Jan 17. 1940. Post mortem Exam.

Immediate cause of death	Duration
Cardio-renal disease	5 years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations None
Of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John M. Claffy Deputy medical examiner (M. D. or other)
Address Anne Arundel Date signed 1/18/40

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

JAN 23 1940
BUREAU V. S.

0174

STATE OF MARYLAND—CERTIFICATE OF DEATH

1. PLACE OF DEATH (186-a)

County: Anne Arrundel — Registration Dist. No. 25

Village or City: Brooklyn Heights — No. ____ St., ____ Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U.S. if of foreign birth? ____ yrs. ____ mos. ____ ds.

2. FULL NAME Annie E Recker — If U. S. Veteran, specify WAR ____

(a) Residence: No. 15 Doris Ave (Usual place of abode) St., ____ Ward. ____ If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: John J Recker

6. DATE OF BIRTH (month, day, and year): March 25, 1879

7. AGE: Years 60 — Months 9 — Days 29 — If LESS than 1 day, ____ hrs. or ____ min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.: Bathtime

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year) ____

11. Total time (years) spent in this occupation ____

12. BIRTHPLACE (city or town) (State or country): Balto Md

FATHER

13. NAME: Edwin C. Hill

14. BIRTHPLACE (city or town) (State or country): Va.

MOTHER

15. MAIDEN NAME: Lydia Higdon

16. BIRTHPLACE (city or town) (State or country): Dont know

17. INFORMANT (Address): John J. Recker, 15 Doris Ave.

18. BURIAL, CREMATION, OR REMOVAL — Place: Mt Olivet — Date: Jan. 30, 1940

19. UNDERTAKER (Address): A. Howard Evans, 1408-02 St Charles Nor

20. FILED: January 28, 1940 — Ida M. Whitson, Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH January 27, 1940 (Month) (Day) (Year)

22. I HEREBY CERTIFY That I attended deceased from Jan 24, 1940, to Jan 27, 1940

I last saw her alive on Jan 27, 1940; death is said to have occurred on the date stated above, at 9.10 a.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Cerebral Hemorrhage	1-24-40
Malignant Hypertension	unknown
Myocardial Degeneration	"

Other Contributory Causes of importance:

Fracture of Right Clavicle	1-24-40
Terminal Bronchopneumonia	1-26-40

Name of operation ____ Date of ____

What test confirmed diagnosis? Clinical — Was there an autopsy? no

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? ____ Date of Injury ____, 19__

Where did injury occur? ____ (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE. see other side

Manner of injury ____

Nature of injury ____

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify ____

(Signed) Lawrence M. Sena M. D.

(Address) 1009 Annapolis Blvd

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

(T)

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I		Example II	
The principal cause of death and related causes of importance were as follows:	Date of onset	The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*	*Attack of epilepsy*	*1 week ago*
Chronic interstitial nephritis	*1921*	*Run over by street car*	*1 week ago*
Cerebral hemorrhage	*July 5, 1927*	*Peritonitis*	*3 days ago*
Other contributory causes of importance:		Other contributory causes of importance:	
Gallstones	*May 1, 1923*	*Gastroenteritis*	*1 year*

RECEIVED FEB 3 1944 BUREAU V. S.

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

Injury sustained was due to a fall as a result of the cerebral hemorrhage—

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

0175

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 30-9

CERTIFICATE OF DEATH

Reg. Dist. No. 22

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Jessups
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: House of Correction Hospital
Stay in hospital or inst. (yrs., or mos., or days): 12 hours
Stay in this community (yrs., or mos., or days): 12 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: 513 Mulberry St Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: Baltimore
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Grace Riley alias Grace Luke

3. (b) Social Security Number

4. Sex: female
5. Color or race: white
6. (a) Single, married, widowed, or divorced: divorced
6 (b) Name of husband or wife: —
6(c) If alive, give age: — years
7. Birth date of deceased (mo., day, yr.): March 13. 1902

8. AGE: Years: 37 Months: 10 Days: 8 If less than one day: hrs. min.

9. Birthplace: Hagerstown, Md (Town, county, and state)
10. Usual occupation: domestic
11. Industry or business: —
FATHER 12. Name: John McIntire
13. Birthplace: not known
MOTHER 14. Maiden name: Helen Grover
15. Birthplace: not known
16. Informant: Dr. LeRoy Wright. Warden
Address: House of Correction
17. Burial (Burial, cremation, or removal. Which?) Date thereof: January 30 40 (month) (day) (year)
Cemetery or crematory: Cherry Hill
Location: Jessup, Md of C.
18. Funeral director: H. L. Collins
Address: Jessup. Md
19. Jan 29 1940 (Date rec'd by registrar) Clara W. Casleup Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jany. 21 1940, at 7:10 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Post. mortem examination
and that I last saw h alive on 19
Immediate cause of death: Coronary Thrombosis
Due to: Lues
Due to: Chronic Alcoholism
Other conditions
(Include pregnancy within 3 months of death)
Major findings: Of operations: none
Of autopsy: None

DURATION: sudden; 5 or more years; 5 years or more

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: John M. Claffey Deputy medical examiner M. D. or other
Address: Annapolis, Md. Date signed 1/21/40

RECEIVED
FEB 6 1940
BUREAU Y. S.

0176

STATE OF MARYLAND—CERTIFICATE OF DEATH

40184 - Ahebbe (131-C)

1. PLACE OF DEATH

County Anne Arundel Registration Dist. No. 25

Village or City Brooklyn Park No. 113 15th Ave ~~St.~~, Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ____ yrs. 1 mos. ____ ds. How long in U.S. if of foreign birth? 60 yrs. ____ mos. ____ ds.

2. FULL NAME John Rommel If U. S. Veteran, specify WAR ——

(a) Residence: No. Pt. Pleasant Rd. Box 257 (A.A.Co.) St., ____ Ward. ——

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Anna Rommel

6. DATE OF BIRTH (month, day, and year): March 19, 1864

7. AGE: Years 75 | Months 10 | Days 2 | If LESS than 1 day, ____ hrs. or ____ min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.: Retired (20 yrs)

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country): Germany

FATHER

13. NAME: Don't Know

14. BIRTHPLACE (city or town) (State or country)

MOTHER

15. MAIDEN NAME

16. BIRTHPLACE (city or town) (State or country): Don't Know

17. INFORMANT: Mrs. Anna Rommel (Wife)

(Address) 113 15th St - Brooklyn Pk., Md.

18. BURIAL, CREMATION, OR REMOVAL

Place Mt. Olivet Date Jan. 23, 1940

19. UNDERTAKER: A. Howard Evans

(Address) 1400-02 S. Charles St. - Balto., Md.

20. FILED Jan 22, 1940 Ida M. Whitsons Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Jan (Month) 21 (Day), 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from Dec 26, 1940, to Jan 21, 1940

I last saw him alive on Jan 21, 1940; death is said to have occurred on the date stated above, at 12.40 m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Chronic Endocarditis	3 mo
Other Contributory Causes of Importance:	
Chronic Bright's Disease	4 mo
General Anasarca	2 mo.

Name of operation ____ Date of ____

What test confirmed diagnosis? ____ Was there an autopsy? No

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? ____ Date of injury ____, 19__

Where did injury occur? ____ (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury ____

Nature of injury ____

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify ____

(Signed) C. B. Mielke M. D.

(Address) 1279 Melsam N

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as **at school** or **at home**. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and own **home** in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel**, etc. For a person who had no occupation whatever write **none**.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver**, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill**, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer**, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist**, etc. Distinguish carefully between **retail merchants** and **wholesale merchants**. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

RECEIVED FEB 6 1940 BUREAU V. S.

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

0177

Reg. Dist. No. 22

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Odenton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days): 70 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County:
City or town: Odenton Md Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Rebecca Ruth Sanford

3. (b) Social Security Number: None

4. Sex: F
5. Color or race: W
6. (a) Single, married, widowed, or divorced:
6 (b) Name of husband or wife: Wm H. Sanford
6 (c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): May 12 - 1864
8. AGE: Years 75 Months 9 Days 17 If less than one day: hrs. min.
9. Birthplace: Odenton Md (Town, county, and state)
10. Usual occupation: Hwf.
11. Industry or business
FATHER 12. Name: Unknown
13. Birthplace: Unknown
MOTHER 14. Maiden name: Unknown
15. Birthplace: Unknown
16. Informant: Wayford Disney
Address: Severn Md.
17. Burial (Burial, cremation, or removal, Which?) Date thereof: Jan 31, 1940 (month) (day) (year)
Cemetery or crematory: Nichols Mem. Cemetery (Annex)
Location: Odenton Md
18. Funeral director: Wm J. Ticknor & Sons
Address: Balto Md
19. Jan 29 1940 (Date rec'd by registrar) W. L. Jones D L Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 29 1940, at 24 hrs.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 5 1939, to Jan 29 1940 and that I last saw him alive on Jan 28 - 1940.
Immediate cause of death: Chronic Hypertension
Due to: Cardio Vascular Renal Disease
Due to:
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Joseph Lipsky M. D. or other
Address: Odenton Md Date signed: Jan 29-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
FEB 8 1940
BUREAU V. S.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8)

WITHIN CORPORATE LIMITS OF

CERTIFICATE OF DEATH

0178

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: apt. 5 Compmise st

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 5 Compmise apt. 5
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Stillhorn Savoy

3. (b) Social Security Number: None

4. Sex: Female

5. Color or race: Col.

6. (a) Single, married, widowed, or divorced: H

6 (b) Name of husband or wife: H

6(c) If alive, give age: H years

7. Birth date of deceased (mo., day, yr.): Jan 25 1940

8. AGE: Years: Stillhorn; Months: X; Days: X; If less than one day: X hrs. X min.

9. Birthplace: Annapolis Md.
(Town, county, and state)

10. Usual occupation: X

11. Industry or business

FATHER
12. Name: William Savoy
13. Birthplace: Annapolis Md. AACO

MOTHER
14. Maiden name: Alice Woods
15. Birthplace: Severna Park Md.

18. Informant: William Savoy

Address: 5 Compmise st.

17. Brewhill (Burial, cremation, or removal. Which?) Date thereof: Jan. 26 1940 (month) (day) (year)

Cemetery or crematory: Brewhill cemetery

Location: On Washington rd. Outside

18. Funeral director: Chas. H. Alexander Annapolis

Address: 43.45 Northwest st

19. 1 26 1940 (Date rec'd by registrar) J. J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jany. 25 1940, at 12 P.M. 30

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Post mortem examination

and that I last saw h alive on 19

Immediate cause of death: Still-birth

Due to: premature infant

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations: none

Of autopsy: none

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: John M. Claffy Deputy medical examiner M. D. or other

Address: Annapolis Md. Date signed: 1/25/40

RECEIVED
FEB 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0179

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Crownsville State Hospital

Stay in hospital or inst. (yrs., or mos., or days): 3 mos. 14 days

Stay in this community (yrs., or mos., or days): ------

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: At Large An. County: Anne

City or town: Md. House of Correction Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Unknown

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: Unknown

3. (a) FULL NAME: William Shields

3. (b) Social Security Number: 209-03-2941 Rose

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	single

6 (b) Name of husband or wife: -------

6(c) If alive, give age: ----- years

7. Birth date of deceased (mo., day, yr.): 1883 ?

8. AGE: Years: 57? Months: Unknown Days: ---- If less than one day: ---- hrs. ---- min.

9. Birthplace: Tenna. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: -------

FATHER — 12. Name: George Shields

FATHER — 13. Birthplace: Alabama

MOTHER — 14. Maiden name: Emma (Unknown)

MOTHER — 15. Birthplace: Alabama

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. Burial, cremation, or removal. Which?: Burial Date thereof: 1/11-40 (month) (day) (year)

Cemetery or crematory: Hospital

Location: Crownsville Md

18. Funeral director: Supt

Address

19. (Date rec'd by registrar) Jan 11 1940 Registrar: E. F. Joyce DLC

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 5th, 1940, at 4 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 22nd 1939 to January 5 1940, and that I last saw him alive on January 5th 1940

Immediate cause of death	DURATION
General Paralysis of the Insane	
Due to	
Due to	
Other conditions: Lues	

(Include pregnancy within 3 months of death)

Major findings:

Of operations: -------

Of autopsy: -------

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ---------- Date of

Where did injury occur?: ---------- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): -------

Means of injury: ------- Injured at work?

23. SIGNATURE: Chas. J. Armiger M. D. or other

Address: Crownsville, Maryland Date signed: 1/5/40

RECEIVED
FEB 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0180

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Crownsville State Hospital

Stay in hospital or inst. (yrs., or mos., or days): 13 days

Stay in this community (yrs., or mos., or days): 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore City

City or town: Baltimore City Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Unknown
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: ----------

3. (a) FULL NAME: Thomas Simms

3. (b) Social Security Number: 214-05-2306 & 215-12-5351 Rev.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Black	Unknown

6 (b) Name of husband or wife: Unknown

6(c) If alive, give age ---- years

7. Birth date of deceased (mo., day, yr.): 1890 (?)

8. AGE: Years	Months	Days	If less than one day
50 (?)	Unknown		---- hrs. ---- min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: ----------

FATHER
12. Name: Daniel Simms
13. Birthplace: Virginia

MOTHER
14. Maiden name: Lizzie Robinson
15. Birthplace: Virginia

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/17/40 (month) (day) (year)

Cemetery or crematory: Hospital

Location: Crownsville Md

18. Funeral director: Supt.

Address: Crownsville

19. (Date rec'd by registrar) 1/17 1940 EJ Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 12 1940, at 7:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 31 1939, to January 12 1940, and that I last saw him alive on January 12 1940.

Immediate cause of death	DURATION
Myocardial Degeneration	
Due to: Senile Psychosis	
Due to: ----------	
Other conditions: ----------	

(Include pregnancy within 3 months of death)

Major findings:

Of operations: ----------

Of autopsy: none

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ---- Date of: ----

Where did injury occur? ---- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ----

Means of injury: ---------- Injured at work?

23. SIGNATURE: Herbert Simmons M. D. or other

Address: Crownsville Md Date signed 1/13/40

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
FEB 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (191-2)

CERTIFICATE OF DEATH

0181

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 62 Washington Street
Stay in hospital or inst. (yrs., or mos., or days): [illegible]
Stay in this community (yrs., or mos., or days): 67 Years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis Ind Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 62 Washington St
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: None.

3. (a) FULL NAME: Martha Sisco

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem-	Col	Married

6 (b) Name of husband or wife: Alexander Sisco
6(c) If alive, give age: 70 years

7. Birth date of deceased (mo., day, yr.): Sept 26 1883

8. AGE:

Years	Months	Days	If less than one day
56 7	3	16	____ hrs. ____ min.

9. Birthplace: St Margrets a-a-co- Maryland
(Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business: at Home.

FATHER
12. Name: Richard Lindsay
13. Birthplace: St Margrets a-a-co- Md.

MOTHER
14. Maiden name: Harriet Henson
15. Birthplace: St Margrets a-a-co- Md

16. Informant: Alexander Sisco
Address: 62 Washington St- annapolis

17. Brewerhill Cemt- (Burial, cremation, or removal. Which?) Date thereof: Jan 19 1940 (month) (day) (year)
Cemetery or crematory: Brewerhill Cemt-
Location: annapolis Maryland

18. Funeral director: E H B Parker
Address: 47 Washington St

19. 1/16 1940 (Date rec'd by registrar) J. J. Murphy Jr. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 12 1940, at 9:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1936, to Jan 12 1940, and that I last saw h- alive on June 12 1940.

	DURATION
Immediate cause of death: Uremic Pulmonary Edema	3 days
Due to: Chr. Myocarditis & Hypertension	yrs.
Due to: Chr. Nephritis	yrs.
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Maurice F. Klaware, M.D. (M. D. or other)
Address: 31 South Gate Av Date signed: 1/16/40

RECEIVED
FEB 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

0182

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Crownsville State Hospital
Stay in hospital or inst. (yrs., or mos., or days): 2 yrs. 2 mos. 9 das.
Stay in this community (yrs., or mos., or days): -----

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George's
City or town: Unknown Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: Unknown
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: -------

3. (a) FULL NAME: ARTHUR SMITH

3. (b) Social Security Number: ------

4. Sex: Male

5. Color or race: black

6. (a) Single, married, widowed, or divorced: widowed

6 (b) Name of ~~husband~~ or wife: Unknown

6(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): Virginia 1856

8. AGE: Years: 84 Months: Unknown Days: If less than one day: ---- hrs. ---- min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual occupation: Farm laborer

11. Industry or business: -----

FATHER
12. Name: John W. Smith
13. Birthplace: Virginia

MOTHER
14. Maiden name: Mary Gallager
15. Birthplace: Virginia

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. burial (Burial, cremation, or removal. Which?) Date thereof 1-27-40 (month) (day) (year)
Cemetery or crematory: Hospital Cem-
Location: Crownsville
18. Funeral director: Supt
Address

19. 1-27-40 (Date rec'd by registrar) 19 E J Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 18th 19 40 at 7 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 9th 19 37, to Jan. 18 19 40
and that I last saw him alive on Jan. 18th 19 40

Immediate cause of death	DURATION
Chronic myocarditis	
Due to	
Due to	
Other conditions: Senile psychosis	

(Include pregnancy within 3 months of death)

Major findings:
Of operations: --------
Of autopsy: ------

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: --- Date of
Where did injury occur? ----- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): -----
Means of injury: ------ Injured at work?

23. SIGNATURE: Arthur T. Smith M. D. or other
Address: Crownsville, Maryland Date signed 1/18/40

RECEIVED
FEB 15 1940
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0183

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Crownsville State Hospital

Stay in hospital or inst. (yrs., or mos., or days): 2 yrs. 9 mos. 4 das

Stay in this community (yrs., or mos., or days): -----

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Catonsville Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 46 Winters Avenue
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: ------

3. (a) FULL NAME: ELVIRA SMITH

3. (b) Social Security Number: ------

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
female	black	single

6 (b) Name of husband or wife: ------

6(c) If alive, give age: ---- years

7. Birth date of deceased (mo., day, yr.): 1910

8. AGE: Years: 30 Months: Unknown Days: If less than one day: ---- hrs. ---- min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: -------

FATHER
12. Name: Alexander Smith
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary L. Smith
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Athallon Howard Co. Date thereof: Jan 21, 1940
(Burial, ~~cremation~~, or removal. Which?) (month) (day) (year)

Cemetery or crematory: Athallon Howard Co.

Location: Howard Co. Md.

16. Funeral director: Mrs. S. T. Hemsley

Address: 578 W. Biddle St. Balto. Md

19. 1/17, 1940 (Date rec'd by registrar) E. F. Joyce DL Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 16th 1940, at 11:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 12th, 1937, to Jan. 16th 1940, and that I last saw her alive on Jan. 16th 1940.

Immediate cause of death: Tuberculous peritonitis and tuberculous pleuritis

Due to:

Due to:

Other conditions: ------
(Include pregnancy within 3 months of death)

Major findings:
Of operations: ------
Of autopsy: ------

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ---- Date of:

Where did injury occur? ---- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): -----

Means of injury: --- Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Crownsville, Md. Date signed: 1/16/40

RECEIVED
JAN 21 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0184

Reg. Dist. No. 20

1. PLACE OF DEATH:

County Anne Arundel

City or town Drury
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 40 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Drury Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Hester Smith

3. (b) Social Security Number None

4. Sex F

5. Color or race C

6. (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife Arthur Smith

6(c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) Jan 1 1889

8. AGE: Years 51 Months 0 Days 6 If less than one day ___ hrs. ___ min.

9. Birthplace Anne Arundel Co. Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Andrew Smith
13. Birthplace Anne Arundel County, Md

MOTHER
14. Maiden name Elizabeth Stewart
15. Birthplace Anne Arundel County, Md.

16. Informant Arthur Smith

Address Drury, Md.

17. Burial
(Burial, cremation, or removal. Which?)

Date thereof Jan 9 1940
(month) (day) (year)

Cemetery or crematory Moses Cemetery

Location Drury, Md.

18. Funeral director T. A. Hardesty & Son

Address Galesville, Md.

19. 1/9 1940 H. R. Clayton
(Date rec'd by registrar) Nephew Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 7 1940, at 9.45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 3 1940, to Jan 7 1940, and that I last saw her alive on Jan 7 1940.

Immediate cause of death Abscess of lung: caused by suspected tuberculosis. C.W.G.R.

DURATION 5 day

Due to

Due to Chronic Nephritis

for 3 & 4 months

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Reverdy Sasser
M. D. or other

Address Upper Marlboro Date signed 7/8/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

I

T

RECEIVED
FEB 8 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

WITHIN CORPORATE LIMITS OF (50)

CERTIFICATE OF DEATH

Reg. Dist. No. 4 0185

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 18 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Annapolis Md. Ward No. 2
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 74 Charles
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR no

3. (a) FULL NAME Margaret P. Smith

3. (b) Social Security Number none

4. Sex: Female
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Frank C. Smith
6(c) If alive, give age: 54 years
7. Birth date of deceased (mo., day, yr.): Oct 7th 1893
8. AGE: Years 46 Months 3 Days 23 If less than one day ____ hrs. ____ min.
9. Birthplace: Frostburg Md. (Town, county, and state)
10. Usual occupation: Home Corpe
11. Industry or business
FATHER 12. Name: Fred Crowe
13. Birthplace: Frostburg Md.
MOTHER 14. Maiden name: Manie Pengully
15. Birthplace: Frostburg Md.
16. Informant: Frank C. Smith
Address: 74 Charles St. Annapolis Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feby 12 1940 (month) (day) (year)
Cemetery or crematory: Cedar Bluff
Location: Annapolis Md.
18. Funeral director: John M. Taylor
Address: Annapolis Md.
19. 1-30 1940 (Date rec'd by registrar) J. J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 30 1940, at 3.30 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1938 19__ to Jan 30 1940, and that I last saw her alive on Jan. 30 1940.

Immediate cause of death	DURATION
(a) General Carcinomatosis	
Due to (b) Carcinoma Breast	1938
Due to (c) Secondary Anaemia	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings: Of operations: Carcinoma Breast
Of autopsy:

PHYSICIAN Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ____ Date of ____
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. Willis Martin M.D. M. D. or other
Address Annapolis Md Date signed 1/30/40

RECEIVED
FEB 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

0186

Reg. Dist. No. [illegible]

1. PLACE OF DEATH:

County: Annarundel.

City or town: St Margret

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: — —

Stay in hospital or inst. (yrs., or mos., or days): —

Stay in this community (yrs., or mos., or days): —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland. County: Annerundel

City or town: — — — — Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: — St Margret — md.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: — — —

3. (a) FULL NAME: Infant Stansbury

3. (b) Social Security Number: —

4. Sex: Fem.

5. Color or race: Col-

6. (a) Single, married, widowed, or divorced: Single.

6 (b) Name of husband or wife: Charles Stanbury

Annie Stansbury

6(c) If alive, give age: [illegible] years

7. Birth date of deceased (mo., day, yr.): 2. days Jan. 9, 1940

8. AGE: Years: — Months: Days: 2 It less than one day: ____ hrs. ____ min.

9. Birthplace: St Margrets (Town, county, and state)

10. Usual occupation: None

11. Industry or business: None

FATHER

12. Name: Charles Stansbury

13. Birthplace: St Margrets

MOTHER

14. Maiden name: Annie Hebron

15. Birthplace: St Margrets aa co md

16. Informant: Mrs Stanbury

Address: St Margrets

17. (Burial, ~~cremation, or removal. Which?~~) Date thereof: 1. 13. 1940 (month) (day) (year)

Cemetery or crematory: Broad Neck,

Location: St Margrets

18. Funeral director: E H Blaker

Address: 47 Washington St

19. 1-13 1940. (Date rec'd by registrar) J J Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 11 1940, at 11:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 10 1940, to Jan. 11 1940, and that I last saw her alive on Jan 11 1940.

Immediate cause of death: Atelectasis

Due to: Prematurity (6 mo.)

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Maurice F. Klawans, Jr M. D. or other

Address: 31 Smithgate Av Date signed: 1/12/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
FEB 5 1940
BUREAU V. S.

0187

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (30-8)

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville Md (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Crownsville State Hospital

Stay in hospital or inst. (yrs., or mos., or days): transferred from Johns Hopkins Hosp.

Stay in this community (yrs., or mos., or days): 0

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore Ward No.: (If outside city or town limits, write RURAL NEAR and give town)

Street No.: 1740 Llewellyn Ave (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Willis Stewart

3. (b) Social Security Number:

4. Sex: male

5. Color or race: negro

6. (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Cynthia Stewart

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): not known

8. AGE: Years: 50 ? Months: Days: If less than one day: hrs. min.

9. Birthplace: not known (Town, county, and state)

10. Usual occupation: laborer

11. Industry or business: general

FATHER 12. Name: not known

13. Birthplace:

MOTHER 14. Maiden name: not known

15. Birthplace:

16. Informant: Miss Anne Little

Address: Crownsville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 10 '40 (month) (day) (year)

Cemetery or crematory: Mount Calvary

Location: Anne Arundel Co. Md

18. Funeral director: Byron & Mamie Wright

Address: 1218 McEldery St Balto

19. Jan 6 1940 (Date rec'd by registrar) E F Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jany 5 1940, at 11 30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 , to 19 , and that I last saw it alive on Post mortem exam. 19

Immediate cause of death: General Paresis — DURATION: not known

Due to: Lues — not known

Due to: (Died while being transported from Johns Hopkins Hospital to Crownsville.)

Other conditions: (Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: John M. Claffy Deputy medical examiner M. D. or other

Address: Annapolis Md Date signed: 1/5/~~39~~ 40

VS A15 (T) MARGIN RESERVED FOR BINDING (M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 12 1940
BUREAU V. S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

0188

V. S. No. 1

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH

County A A Co. Registration Dist. No. 21

Village or City Annapolis No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 73 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Charles E. Suit

(a) Residence: No. 827 West St., Ward.

(Usual place of abode)

Social Security No 212-14-2751

If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
M	W	Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, and year) July 6th 1866

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	5	1	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Grocery Store

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year) Feb 4/40

11. Total time (years) spent in this occupation 60

12. BIRTHPLACE (city or town) (State or country) A A Co

FATHER

13. NAME Benjamin S Suit

14. BIRTHPLACE (city or town) (State or country) Prince Ges Co

MOTHER

15. MAIDEN NAME Anna Sophie Sheckells

16. BIRTHPLACE (city or town) (State or country) A A Co

17. INFORMANT Mrs Margaret Sydings

(Address) 827 West St

18. BURIAL, CREMATION, OR REMOVAL

Place Cedar Cliff Cem. Date Feb 7, 1940

19. UNDERTAKER Robert F. Suit

(Address) 829 West St

20. FILED Feb 7, 1940 J. M. Murphy Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Jan (Month) 5 (Day) 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from Jan 5 - 3 pm, 1940, to Jan 5 - 7 pm, 1940

I last saw h. alive on Jan 5, 1940; death is said to have occurred on the date stated above, at 10 p. m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Acute Dilatation & Heart Degeneration & Myocardial Insufficiency	2-5-40
	Intermin
Other Contributory Causes of importance: Arteriosclerosis	unknown

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy? No

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) George C Bond M. D.

(Address) Annapolis Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

RECEIVED

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

0189

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Crownsville State Hospital
Stay in hospital or inst. (yrs., or mos., or days): 1 mo. 10 das.
Stay in this community (yrs., or mos., or days): -----

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: ~~Anne Arundel~~
City or town: Baltimore City Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 822 North Carrollton Avenue
(If rural, give LOCATION)
2(a) IF VETERAN, NAME WAR: Unknown

3. (a) FULL NAME: Wm/ TERRELL

3. (b) Social Security Number: Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	widowed

6 (b) Name of husband or wife: Unknown
6(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): 1873

8. AGE:

Years	Months	Days	If less than one day
67	Unknown		____ hrs. ____ min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: ------

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 29 1940 (month) (day) (year)
Cemetery or crematory: Mt. Auburn
Location: Balto. Md.
18. Funeral director: Mrs Samuel I Hensley
Address: 578 N. Biddle St.

19. Jan 26 1940 (Date rec'd by registrar) E.T. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 24th 1940, at 9:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 14th, 1939, to Jan. 24th 1940, and that I last saw him alive on Jan. 24th 1940.

Immediate cause of death: Diabetes — DURATION
Due to: ____
Due to: ____
Other conditions: Senile psychosis - paranoid type
(Include pregnancy within 3 months of death)

Major findings:
Of operations: -----
Of autopsy: -------

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ---- Date of: ----
Where did injury occur? ----- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): -----
Means of injury: ------- Injured at work?

23. SIGNATURE: Ord & Tom Brooks M. D. or other
Address: Crownsville, Md. Date signed: 1/24/40

RECEIVED
FEB 5 1940
BUREAU V. S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

0190

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

1. PLACE OF DEATH (3)

County Anne Arundel Registration Dist. No. 22

Village or City Georgetown No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Baby Boy Thompson

(a) Residence: No. Jessup Md St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
M	C	S

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, and year) Jan. 16, 1940

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
Stillborn			

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Jessup Md
(State or country)

FATHER

13. NAME Wm Harris

14. BIRTHPLACE (city or town) Hanover Md
(State or country)

MOTHER

15. MAIDEN NAME Gertrude Thompson

16. BIRTHPLACE (city or town) Jessup Md
(State or country)

17. INFORMANT Gertrude Thompson
(Address) Jessup Md

18. BURIAL, CREMATION, OR REMOVAL
Place Georgetown Cem Date Jan 19, 1940

19. UNDERTAKER John Eads
(Address) Jessup Md

20. FILED Jan 18, 1940 Clara M. Harlech
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Stillborn Jan 16, 1940
(Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...

I last saw h... alive on ..., 19...; death is said to have occurred on the date stated above, at ... m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Stillborn	

Other Contributory Causes of Importance:

Name of operation ... Date of ...

What test confirmed diagnosis? ... Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? ... Date of injury ..., 19...

Where did injury occur? ...
(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, In HOME, or in PUBLIC PLACE.

Menner of Injury ...

Neture of injury ...

24. Was diseese or injury in eny way related to occupation of deceased? ...

If so, specify ...

(Signed) W. A. Hudson M. D.

(Address) Laurel, Md

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel,** etc. For a person who had no occupation whatever write **none.**

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver,** etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill,** etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer,** etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist,** etc. Distinguish carefully between **retail merchants** and **wholesale merchants.** A person who sells goods should be called a **salesman** and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

RECEIVED FEB 6 1940 BUREAU V. S.

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

0191

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Emergency Hospital
Stay in hospital or inst. (yrs., or mos., or days): /
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infant give residence of mother)
State: Maryland County: Anne Arundel
City or town: Crownsville Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: Generals' Highway
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Dorothy Mae Todd

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	S

6 (b) Name of husband or wife: —

6(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Sept. 23. 1939

8. AGE:

Years	Months	Days	If less than one day
	3	26	____ hrs. ____ min.

9. Birthplace: Crownsville, Md
(Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER
12. Name: Walter H. Todd
13. Birthplace: Cherrydale. Va

MOTHER
14. Maiden name: Agnes Lowman
15. Birthplace: Waterbury. Md

16. Informant: Walter H Todd
Address: Crownsville,

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 22 1940 (month) (year)

Cemetery or crematory: Baldwin memorial
Location: Millersville md
18. Funeral director: B E. Hopkins
Address: annapolis. md.

19. 1 22 1940 (Date rec'd by registrar) J J M Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jany. 18 1940, at 10 40 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jany. 14 1940, to Jany. 18 1940, and that I last saw her alive on Jany. 18 1940.

Immediate cause of death: Croupous Pneumonia — DURATION: 4 Days

Due to: —

Due to: —

Other conditions: —

(Include pregnancy within 3 months of death)

Major findings: None done

Dt operations: —

Dt autopsy: none done

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: John M. Slaffy M.D
M. D. or other
Address: Annapolis Md Date signed 1/18/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS AT5

RECEIVED
FEB 5 1940
BUREAU V. S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

0192

1. PLACE OF DEATH (83a)

County Anne Arundel Registration Dist. No. 26

Village or City Deale No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Samuel Tyler If U. S. Veteran, specify WAR

(a) Residence: No. Deale, Md St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
male	col	married

5a. If married, widowad, or divorced HUSBAND of (or) ~~WIFE of~~ Rebecca Tyler

6. DATE OF BIRTH (month, day, end year) Jan 12-1863

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	0	14	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Farmer

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceasad last worked at this occupation (month and year) —

11. Total time (years) spent in this occupation —

12. BIRTHPLACE (city or town) (Stata or country) Anne Arundel Co Md

FATHER

13. NAME Williams Tyler

14. BIRTHPLACE (city or town) (State or country) Friendship A.A.Co. Md.

MOTHER

15. MAIDEN NAME Frances Estep

16. BIRTHPLACE (city or town) (State or country) Unknown.

17. INFORMANT Wilson Tyler (Address) Deale Md

18. BURIAL, CREMATION, OR REMOVAL Place Tyler Burying Grd Date Jan 31, 1940

19. UNDERTAKER T. A. Hardesty & Son (Address) Galesville Md.

20. FILED Jan 30, 1940 T. B. Dent. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Jan (Month) 26 (Day), 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from January, 1937, to Jan 25, 1940

I last saw h— alive on January 25, 1940; deeth is said to have occurred on tha date stated ebove, at 1. P. m.

The PRINCIPAL CAUSE OF DEATH end related causes of importance were as follows:

	Date of onset
Cerebral Hemorrhage	11 days ago
Broncho pneumonia	10 days ago

Other Contributory Causes of importance:

Name of operation Date of

What tast confirmed diagnosis? None Was there an autopsy? no

23. If death was due to external causes (VIOLENCE) fill in eiso the following:

Accident, suicida, or homicide? Date of Injury, 19

Whera did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was diseasa or injury in any way related to occupation of decaased? no

If so, specify

(Signed) Samuel M. Reichel M. D.

(Address) Annapolis, Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (44E)

0193

WITHIN CORPORATE LIMITS OF

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne Arundel

City or town Annapolis,
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 211 Hanover St.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Annapolis, Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 211 Hanover St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME

CONSTANCE A. VOLK

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Divorced

B (b) Name of husband or wife Henry Volk

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 31, 1897

8. AGE: Years	Months	Days	If less than one day
42		19	hrs. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER
12. Name John Roland Brady
13. Birthplace Annapolis, Md.

MOTHER
14. Maiden name Loretta Bottomer
15. Birthplace Baltimore, Md.

16. Informant Miss Elizabeth Brady
Address Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 23 1940 (month) (day) (year)

Cemetery or crematory St. Mary's Cemetery

Location Annapolis, Md.

18. Funeral director John M. Taylor

Address Annapolis, Md.

19. 1-23 1940 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 20 1940, at 11 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1938 to Jan 20 1940, and that I last saw her alive on Jan 20 1940

Immediate cause of death	DURATION
Acute Dilatation of Heart.	Jan 20.
Due to Hodgkins Disease	4 years.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE George C Bond M. D. or other

Address Annapolis Date signed 1-22-40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
FEB 5 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (159)

0194

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Greenock
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: A. A.
City or town: Greenock Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: None

3. (a) FULL NAME: Albert Raymond Wallace

3. (b) Social Security Number

4. Sex: M
5. Color or race: Col
6. (a) Single, married, widowed, or divorced: —
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): Jan 21 1940

8. AGE: Years | Months | Days: 3 | If less than one day: hrs. min.

9. Birthplace: Greenock Md
(Town, county, and state)
10. Usual occupation: —
11. Industry or business

FATHER
12. Name: James Henry Wallace
13. Birthplace: Anne Arundel Co Md

MOTHER
14. Maiden name: Blanche I. Sillman
15. Birthplace: Anne Arundel Co Md

16. Informant: James Henry Wallace
Address: Greenock Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/25/40 (month) (day) (year)
Cemetery or crematory: Mt Zion
Location: Lothian, Md

18. Funeral director: James Henry Wallace
Address: Greenock, Md

19. 1/25/40 19 (Date rec'd by registrar) W. R. Claytor Dep Mil Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 24 1940, at 6:38 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 21 1940, to Jan 24 1940, and that I last saw him alive on Jan 23 1940.

Immediate cause of death: Premature birth
Due to
Due to
Other conditions
(Include pregnancy within 8 months of death)
Major findings:
Of operations
Of autopsy

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Kennedy Sussex M. D. or other
Address: Upper Marlboro Md Date signed 1-28-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
FEB 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (41)

CERTIFICATE OF DEATH

0195

Reg. Dist. No. 7

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Anne Arundel
City or town West Annapolis
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town West Annapolis Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. Annapolis & Eutaw Ave
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR no

3. (a) FULL NAME Rosamond T. Waters

3. (b) Social Security Number no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Charles Waters
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 27th 1877

8. AGE: Years	Months	Days	If less than one day
62	1	4	hrs. min.

9. Birthplace Annapolis Md.
(town, county, and state)
10. Usual occupation House
11. Industry or business
FATHER 12. Name William H. Saunenig
13. Birthplace Baltimore Md
MOTHER 14. Maiden name Henretta Basil
15. Birthplace Annapolis Md
16. Informant Mrs Vinton W. Phillips
Address West Annapolis Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 3 1940 (month) (day) (year)
Cemetery or crematory Cedar Bluff
Location Annapolis Md.
18. Funeral director John M. Taylor
Address Annapolis Md.
19. Feb 1st 1940 (Date rec'd by registrar) J. M. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 31 1940, at 2 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 25 1940, to Jan 31 1940, and that I last saw h w alive on Jan 31 1940.

Immediate cause of death Acute Dilatation of Heart — DURATION 1-31

Due to Myocarditis chr — unknown

Due to Hypertension — unknown

Other conditions Diabetes Mellitus — unknown

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the ceuse to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Geo C Bowie M. D. or other
Address Annapolis md Date signed 2-1-40

RECEIVED
FEB 5 1940
BUREAU V. S.

0196

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County A.A.

City or town Annapolis, Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:
Knights of Pythias Building

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 75 Years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County A.A.

City or town Annapolis, Md. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 146 Glouster
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR Spanish American

3. (a) FULL NAME
William H. Weaver

3. (b) Social Security Number
None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Caroline M. Weaver

6(c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) Dec 25 1864

8. AGE:

Years	Months	Days	If less than one day
75		26	hrs. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business Baker Naval Academy

FATHER
12. Name Jacob Weaver
13. Birthplace Germany

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown

16. Informant Caroline M. Weaver

Address 146 Glouster Street Annapolis

17. Burial
(Burial, cremation, or removal. Which?)

Date thereof Jan 23 1940
(month) (day) (year)

Cemetery or crematory Cedar Bluff

Location Annapolis, Md.

18. Funeral director B.L.Hopping

Address Annapolis, Md.

19. 1 23 19 40 J. J. Murphy
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jany. 20 1940, at 9 45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw it alive on Post mortem Examination

Immediate cause of death
Coronary occlusion — DURATION: sudden

Due to
Arterio-sclerosis — not known

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations none

Of autopsy none

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John M. Claffy Deputy medical examiner
M. D. or other

Address Annapolis, Md Date signed 1/22/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

JAN 31 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0197

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Crownsville State Hospital
Stay in hospital or inst. (yrs., or mos., or days): 3 yrs. 7mos. 16 das.
Stay in this community (yrs., or mos., or days): ------

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore City Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 4703 Falls Road
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: ------

3. (a) FULL NAME: MARY WEBSTER

3. (b) Social Security Number: ------

4. Sex: Female
5. Color or race: black
6. (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Talbert Webster
6(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): 1914

8. AGE: Years: 26 Months: Unknown Days: If less than one day: hrs. min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: -----

FATHER
12. Name: Major Patterson
13. Birthplace: Virginia

MOTHER
14. Maiden name: Sarah Branch
15. Birthplace: Virginia

18. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 1-23-40 (month) (day) (year)
Cemetery or crematory: Richmond Va
Location:

18. Funeral director: Saml. W. Chase & Son
Address: 638 N. Gilmor St

19. 1/19.40 19 (Date rec'd by registrar) E. F. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 19th 19 40, at 2:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 2nd 19 36 to Jan. 18 19 40 and that I last saw her alive on Jan. 19th 19 40

Immediate cause of death: Lobar pneumonia — DURATION:
Due to:
Due to:
Other conditions: Dementia Praecox - katatonic type
(Include pregnancy within 3 months of death)
Major findings:
Of operations: ------
Of autopsy: -------

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ---- Date of:
Where did injury occur? ----- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): -----
Means of injury: ----- Injured at work? ------

23. SIGNATURE: [signature] M. D. or other
Address: Crownsville, Md. Date signed: 1/18/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
FEB 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-E)

CERTIFICATE OF DEATH

0198

Reg. Dist. No. 2)

1. PLACE OF DEATH:

County: Anne Arundel County

City or town: Crownsville
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Crownsville State Hospital

Stay in hospital or inst. (yrs., or mos., or days): 13 yrs. 9mos. 24 das.

Stay in this community (yrs., or mos., or days): ------

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Hanover Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Box 831
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: --------

3. (a) FULL NAME: SADIE WILLIAMS

3. (b) Social Security Number: --------

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	black	married

6 (b) Name of husband or wife: Harry Williams

6(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): 1891

8. AGE: Years: 49 Months: Unknown Days: If less than one day: ____ hrs. ____ min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Unknown

11. Industry or business: Unknown

FATHER
12. Name: Thomas Snowden
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. burial (Burial, cremation, or removal. Which?) Date thereof 1 - 11 - 40 (month) (day) (year)

Cemetery or crematory: Hospital

Location: Crownsville

18. Funeral director: Supt

Address

19. Jan 11 1940 (Date rec'd by registrar) E F Joyce DLC Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 7th 1940, at 3:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 13th, 1926, to Jan. 7th 1940, and that I last saw her alive on Jan. 7th, 1940.

Immediate cause of death: Pulmonary tuberculosis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations: ---------

Of autopsy: --------

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ---- Date of

Where did injury occur? ---------- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ------

Means of injury: ---------- Injured at work?

23. SIGNATURE: Joseph J. Mintzioda M. D. or other

Address: Crownsville, Md. Date signed: 1/7/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 (T)

RECEIVED
FEB 5 1940
BUREAU V. S.

0199

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(107)

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Crownsville State Hospital

Stay in hospital or inst. (yrs., or mos., or days): 5 das.

Stay in this community (yrs., or mos., or days): ------

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore City Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 8 South Bethel Street
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: ------

3. (a) FULL NAME: EMMA YOUNG

3. (b) Social Security Number: Unknown

4. Sex: female

5. Color or race: black

6. (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife: ---------

6(c) If alive, give age: ---- years

7. Birth date of deceased (mo., day, yr.): Unknown (Adult)

8. AGE: Years: 40 ? Months: Unknown Days: If less than one day: ___ hrs. ___ min.

9. Birthplace: Unknown
(Town, county, and state)

10. Usual occupation: Unknown

11. Industry or business: ----

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 29, 1940 (month) (day) (year)

Cemetery or crematory: Hospital

Location: Crownsville Md

18. Funeral director: Supt

Address:

19. 1/27 1940 (Date rec'd by registrar) E F Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 24th 1940, at 12:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from A.M. Jan. 19th, 1940, to Jan. 24th 1940, and that I last saw her alive on Jan. 24th 1940.

Immediate cause of death: ~~[illegible] of the [illegible]~~ BRONCHO PNEUMONIA

Due to: ---

Due to: ------

Other conditions: ------
(Include pregnancy within 3 months of death)

Major findings:
Of operations: ------
Of autopsy: ------

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ------ Date of: ------

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ------

Means of injury: ------ Injured at work? ----

23. SIGNATURE: [signature] M. D. or other 1/24/40

Address: Date signed:

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 (T)

RECEIVED
FEB 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(170-C)

CERTIFICATE OF DEATH

0200

Reg. Dist. No. 20

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Lyons Creek
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Highway #416
Stay in hospital or inst. (yrs., or mos., or days): —
Stay in this community (yrs., or mos., or days): —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State: Maryland County: Prince George
City or town: Maryland Park, Seat Pleasant Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: None.

3. (a) FULL NAME: Harry Edward Young

3. (b) Social Security Number: 214-03-0638

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	married

6 (b) Name of husband or wife: Ruth Marshall Young

6(c) If alive, give age: 32 years

7. Birth date of deceased (mo., day, yr.): October 11, 1903

8. AGE:

Years	Months	Days	If less than one day
37	3	11	____hrs. ____min.

9. Birthplace: West Virginia (Town, county, and state)

10. Usual occupation: Dental Mechanic

11. Industry or business: Dentistry

FATHER
12. Name: John P. Young
13. Birthplace: Huntsbey

MOTHER
14. Maiden name: Jenkins
15. Birthplace: Unknown

16. Informant: Ruth Young Seat Pleasant P.O.
Address: 108 Broad St. Maryland Park Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/24/40 (month) (day) (year)

Cemetery or crematory: —

Location: Washington D.C.

18. Funeral director: T.A. Hardesty & Son

Address: Galesville. Md

19. 1/25 1940 (Date rec'd by registrar) W.P. Clayton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 22 1940, at 1:50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Pat. Mortem to Examination and that I last saw h alive on 19

Immediate cause of death	DURATION
Fracture Skull (Base)	Sudden
Due to While driving recklessly	
Due to under influence of liquor	
ran into Lyons Creek	
Other conditions Bridge abutment	
on highway #416	

(Include pregnancy within 3 months of death)

Major findings:
Of operations: None
Of autopsy: None

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of 1/22/40
Where did injury occur? Lyons Creek (City or town) A.A.Co. (County) Md (State)
Injured at home, farm, industry, public place (where?) Highway #416
Means of injury: auto collision Injured at work? no

23. SIGNATURE: John M. Caffey Deputy Medical examiner
M. D. or other
Address: Annapolis, Md Date signed 1/22/40

FEB 1 1940